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Senate of Canada ③

# Of Life and Death

Report of the  
Special Senate Committee on Euthanasia  
and Assisted Suicide

June 1995



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## *Of Life and Death*

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## Report of the Special Senate Committee on Euthanasia and Assisted Suicide

June 1995



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## Membership

The Honourable Joan B. Neiman Q.C., *Chair*  
The Honourable Thérèse Lavoie-Roux, *Vice-Chair*

The Honourable Senators:

Gérald-A. Beaudoin Q.C.  
Sharon Carstairs  
Eymard G. Corbin  
Mabel M. DeWare  
Wilbert J. Keon

\*Joyce Fairbairn P.C. (or Alasdair B. Graham)  
\*John Lynch-Staunton (or Eric A. Berntson)

### ***Original Members agreed to by Motion of the Senate:***

The Honourable Senators:

Beaudoin, DeWare, Gigantès, Keon, Lavoie-Roux, Neiman, Perrault  
\*Fairbairn (or Molgat), \*Lynch-Staunton (or Berntson)

### ***Other Senators who participated in the work of the Committee:***

The Honourable Senators:

Cochrane, Cools, Desmarais, Grafstein, Haidasz, Johnson, Kinsella, Lucier,  
Marchand, Molgat, Nolin, Rossiter, Stratton, Watt

\* *Ex Officio Members*



## Orders Of Reference

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Extract from the *Minutes of the Proceedings of the Senate*, Wednesday, February 23, 1994:

“The Honourable Senator Neiman moved, seconded by the Honourable Senator Lavoie-Roux:

THAT a special committee of the Senate be appointed to examine and report upon the legal, social and ethical issues relating to euthanasia and assisted suicide;

THAT notwithstanding Rule 86(1)(b), the Honourable Senators Beaudoin, DeWare, Gigantès, Keon, Lavoie-Roux, Neiman and Perrault act as members of the special committee, and that three members constitute a quorum;

THAT the Committee have power to send for persons, papers and records, to examine witnesses, to report from time to time and to print such papers and evidence from day to day as may be ordered by the committee; and

THAT the Committee present its final report to the Senate no later than December 15, 1994.

After debate,

The question being put on the motion, it was adopted.”

Gordon L. Barnhart  
*Clerk of the Senate*

Extract from the *Minutes of the Proceedings of the Senate*, Tuesday, November 29, 1994:

“...that the date of presenting its report be extended from December 15, 1994, to no later than March 15, 1995, and that the Committee retain all powers necessary to publicize the findings of the Committee contained in the Final Report until March 30, 1995.

After debate,

The question being put on the motion, it was adopted.”

Paul C. Bélisle  
*Clerk of the Senate*

Extract from the *Minutes of the Proceedings of the Senate*, Wednesday, March 1, 1995:

“THAT notwithstanding the Order of the Senate adopted on Tuesday, November 29, 1994, the Special Senate Committee on Euthanasia and Assisted Suicide, which was authorized to examine the legal, social and ethical issues relating to euthanasia and assisted suicide, be empowered to present its final report no later than May 10, 1995 and that the Committee retain all powers necessary to publicize the findings of the Committee contained in the final report until May 24, 1995.

After debate,

The question being put on the motion, it was adopted.”

Paul C. Bélisle  
*Clerk of the Senate*

Extract from the *Minutes of the Proceedings of the Senate*, Thursday, April 6, 1995:

“THAT the name of the Special Senate Committee on Euthanasia and Assisted Suicide be modified in French to “Comité spécial sur l’euthanasie et l’aide au suicide”.

The question being put on the motion, it was adopted.”

---

Paul C. Bélisle  
*Clerk of the Senate*

Extract from the *Minutes of the Proceedings of the Senate*, Thursday, May 4, 1995:

“THAT notwithstanding the Order of the Senate adopted on Wednesday, March 1, 1995, the Special Senate Committee on Euthanasia and Assisted Suicide, which was authorized to examine the legal, social and ethical issues relating to euthanasia and assisted suicide, be empowered to present its final report no later than May 31, 1995 and that the Committee retain all powers necessary to publicize the findings of the Committee contained in the final report until June 14, 1995.

After debate,

The question being put on the motion, it was adopted.”

Paul C. Bélisle  
*Clerk of the Senate*

Extract from the *Minutes of the Proceedings of the Senate*, Thursday, May 25, 1995:

“THAT notwithstanding the Order of the Senate adopted on Thursday, May 4, 1995, the Special Senate Committee on Euthanasia and Assisted Suicide, which was authorized to examine the legal, social and ethical issues relating to euthanasia and assisted suicide, be empowered to present its final report no later than June 7, 1995 and that the Committee retain all powers necessary to publicize the findings of the Committee contained in the final report until June 21, 1995.

After debate,

The question being put on the motion, it was adopted.”

Paul C. Bélisle  
*Clerk of the Senate*

## Acknowledgements

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The study which this Special Senate Committee undertook would not have been possible without the assistance of a great many people. The members of our small and dedicated Committee, the majority of whom have been with it since its inception in February, 1994 worked tirelessly. Other colleagues came to listen to the witnesses, sometimes to offer opinions and advice and occasionally to replace one of us temporarily. All members added the very demanding schedule of this Committee to their other responsibilities in the Senate and on other committees.

The Committee worked in a totally non-partisan manner. Every member brought his or her own predisposition toward and understanding of the legal, social, moral and other issues involved and yet the group was able to reach an accord on many important issues. It is significant that where we agreed to disagree, we also decided to make those differences and the reasons for them very clear. We hoped that, by so doing, the readers of this Report will be able to follow all of the arguments.

All our colleagues in the Senate, and especially the leadership, deserve a special word of appreciation, not only for giving us the mandate but also the support and resources needed to carry out our study.

Our Report owes much to the individuals and organizations who appeared before our Committee, often on short notice, and who gave us the benefit of their experience and expertise.

The Committee received thousands of letters and even detailed briefs from concerned people and professionals interested in various aspects of our study. All their comments and recommendations have been considered.

We were aided by the services of the Committee staff, Gary Levy, Clerk of the Committee, Michel Patrice and Cathy Piccinin, all of whom gave many hours to serve us well.

The Committee was fortunate to have the services of Jocelyn Downie who, with her legal background and additional experience in the delivery of health care, advised us on the sources of information we would need and how to collect that information in a Report which we hope will prove useful to the public. She prepared the first draft of the Report, which was revised and expanded by Mollie



Dunsmuir, our legal advisor from the Research Branch of the Library of Parliament. A special recognition must be given to Deborah Palumbo, my legal assistant, who revised and wrote the final edition of the Report. She was helped by the assistants of the other members of the Committee, Jacqui Drope, Pierre Thibault, René Leduc and John Terry, who offered recommendations for changes or additions to the text. Courtney Tower provided assistance with rewrites and the media.

The Committee is especially grateful to Jacques Dubé who was responsible for the translation and production of the French text of the Report.

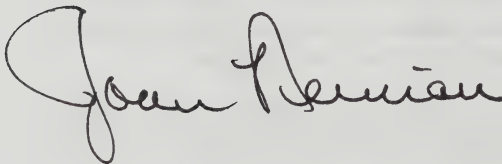
Seven Bulletins were prepared and sent out during the course of the hearings to all the witnesses, the media, including weekly newspapers and radio stations, and all people and organizations who had indicated an interest in our study. Their preparation was the prime responsibility of Marie-Claude LaRose.

The Committee worked long hours over many weeks and often far into the evening requiring the services of a large number of Hansard reporters, interpreters, translators, messengers, technical and secretarial staff who ensured that its work went smoothly. We are grateful to them.

In order to understand the situation in the Netherlands with respect to euthanasia and assisted suicide, the Committee held a day long video-conference with a number of witnesses. We extend our appreciation to everyone involved in this excellent first experience for the Senate.

It was a long and detailed process. As the Chair of the Committee I am grateful to all who assured its thoroughness.

Thank you

A handwritten signature in black ink, reading "Joan B. Neiman". The signature is fluid and cursive, with the first name "Joan" being larger and more prominent than the last name "Neiman".

Joan B. Neiman, Q.C.

## Recommendations

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### Chapter III Palliative Care

The Committee recommends:

- governments make palliative care programs a top priority in the restructuring of the health care system.
- the development and implementation of national guidelines and standards be continued.
- the training of health care professionals in all aspects of palliative care be increased.
- there be an integrated approach to palliative care. The delivery of care, whether in the home, in hospices or in institutions, with the support of volunteers, must be coordinated to maximize effectiveness. The provision of respite services is an essential component.
- research into palliative care, especially pain control and symptom relief, be expanded and improved.

### Chapter IV Pain Control and Sedation Practices

The Committee recommends:

- the *Criminal Code* be amended to clarify the practice of providing treatment for the purpose of alleviating suffering that may shorten life.
- the division of Health Canada responsible for health protection and promotion, in cooperation with the provinces, territories and the national associations of health care professionals, develop guidelines and standards for the provision of treatment for the purpose of alleviating suffering where that may shorten life.
- education and training with respect to pain control be expanded and improved for all health care professionals.
- the division of Health Canada responsible for health protection and promotion, in cooperation with the provinces, territories and the national associations of health care professionals, develop guidelines and standards for the practice of the total sedation of patients.
- the federal government, in cooperation with the provinces and territories, undertake a study in order to determine the frequency and conditions under which total sedation is practised.

## **Chapter V Withholding and Withdrawal of Life-sustaining Treatment**

The Committee recommends:

- the *Criminal Code* be amended and necessary legislation be enacted in order to explicitly recognize and to clarify the circumstances in which the withholding and withdrawal of life-sustaining treatment is legally acceptable. The criteria enunciated in this chapter under “Committee Deliberations” should be considered.
- the division of Health Canada responsible for health protection and promotion, in consultation with the provinces and territories and the relevant professional associations, establish guidelines to govern the withholding and withdrawal of life-sustaining treatment.
- professional guidelines be amended so that they are consistent with these recommendations, the amended *Criminal Code*, and the national guidelines.
- the Federal Ministry of Health, in cooperation with the provinces and territories, sponsor a national campaign designed to inform the public as to their rights with respect to the refusal of life-sustaining treatment.
- research be conducted in order to determine the frequency with which and conditions under which life-sustaining treatment is withheld or withdrawn under the recommended legislation and guidelines.

## **Chapter VI Advances Directives**

The Committee recommends:

- those provinces and territories that do not have advance directive legislation adopt such legislation.
- the provinces and territories establish a protocol to recognize advance directives executed in other provinces and territories.

## **Chapter VII Assisted Suicide**

- The Committee recommends no amendments be made to the offence of counselling suicide under subsection 241 (a) of the *Criminal Code*.
- The majority recommends subsection 241(b) of the *Code* also remain intact.
- The majority recommends research be undertaken into how many are requesting assisted suicide, why it is being requested, and whether there are any alternatives that might be acceptable to those who are making the requests.
- A minority recommends an exemption to subsection 241 (b) of the *Criminal Code* be added, under clearly defined safeguards, to protect individuals who assist in another person’s suicide. These safeguards should include, at a minimum, the elements listed in this chapter under “Committee Deliberations”. They further recommend, that in order to avoid abuse, procedural safeguards must provide for review both prior to and after the act of assisted suicide.



## Chapter VII Euthanasia

### Nonvoluntary Euthanasia

The Committee recommends:

- nonvoluntary euthanasia remain a criminal offence.
- the *Criminal Code* be amended to provide for a less severe penalty in cases where there is the essential element of compassion or mercy. Parliament should consider the following options:
  - *A third category of murder could be created that would not carry a mandatory life sentence but rather would carry a less severe penalty; or*
  - *A separate offence of compassionate homicide could be established that would carry a less severe penalty.*

The essential elements of compassion and mercy must be clearly and narrowly defined in order to limit the cases in which a less stringent sentence would be available.

Parliament should determine the appropriate penalty.

### Voluntary Euthanasia

- The majority recommends voluntary euthanasia remain a criminal offence. The *Criminal Code*, however, should be amended to allow for a less severe penalty similar to that provided for nonvoluntary euthanasia in cases where there is the essential element of compassion or mercy.
- A minority recommends the *Criminal Code* be amended to permit voluntary euthanasia for competent individuals who are physically incapable of committing assisted suicide. This amendment would be subject to the same or similar minimum safeguards as outlined in the chapter on assisted suicide.
- A minority further recommends, that if voluntary euthanasia remains a criminal offence, the *Criminal Code* be amended to provide for a less severe penalty similar to the penalty for nonvoluntary euthanasia.
- The Committee recommends research be undertaken into how many are requesting euthanasia, why it is being requested, and whether there are any alternatives that might be acceptable to those who are making the requests.

### Involuntary Euthanasia

- The Committee recommends the prohibition against involuntary euthanasia continue under the present murder provisions in the *Criminal Code*.



## Introduction

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Throughout the ages, people have reflected upon the issues of death and dying. While most recognize that death is inevitable, fear of the unknown has pervaded such discussions. Different societies have attempted to address these fears and concerns in diverse ways in accordance with their religious or cultural backgrounds and norms in order to make the final passage of life more comforting. With the advent of modern medical technology and the more common usage of artificial measures to prolong life, many people today are more fearful of the process of dying than of death itself.

In recent years, a number of events that received a considerable amount of media attention has prompted many Canadians to consider end of life decisions in order to better prepare for their future.

A series of court decisions in Canada established the right of persons to make some decisions regarding their own medical treatment. Case law strengthened the right of individuals to withhold and withdraw treatment, for example, the 1992 *Nancy B* decision. In that case, the Quebec Superior Court granted a competent woman suffering from Guillain-Barré syndrome, an incurable neurological disease which left her incapable of movement, permission to cease treatment with a respirator at a time of her choosing. This is reflected in the consideration and enactment by most provincial legislatures, that had not already done so, of some form of legislation regarding advance directives, living wills and substitute decision-makers.

More recently, the focus has been to consider assisted suicide and euthanasia. In 1993, the Supreme Court of Canada in the *Sue Rodriguez* decision canvassed the issue of whether the prohibition in the *Criminal Code* against assisted suicide violates the *Canadian Charter of Rights and Freedoms*. The majority of the Court upheld the prohibition but the public debate continues.

Polls taken over the last few years have consistently indicated a growing support for people being able to take control of the dying process, although there are differences of opinion as to whether the people who were polled had sufficient understanding of the exact nature of what they were considering.

In 1993, the Canadian Medical Association, recognizing the need for its involvement and guidance on these issues, published a series of five papers. In so doing, its goal was

## Introduction

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twofold: “to educate Canadian physicians about the ethical, legal and social aspects of euthanasia and assisted suicide” and “to present a physician perspective on these issues to patients, other health professionals, public policy officials and academics”.<sup>1</sup> The membership of the CMA appears to be divided on the issue of assisted suicide and euthanasia; however, they are continuing their study.

It was within this context that a Special Committee of the Senate of Canada, appointed on February 23, 1994, undertook “to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide”. The Committee heard testimony for 14 months from witnesses all across Canada and received hundreds of additional letters and briefs; thus, the full range of opinions on the various issues were fairly represented. This did not make the task of reaching a Committee consensus on the issues any easier. Although the Committee was able to agree on many aspects regarding medical and health care practices, the opinions of the members were divergent on the more difficult questions of assisted suicide and euthanasia.

The study also provided an opportunity to assist all members of Parliament who will be debating the issues on a non-partisan basis culminating in a free vote in Parliament. The Committee also hoped through this Report to help the public to develop a better understanding of this very complex subject. The goal of the Committee was simply to set the stage for the full and open national debate that will take place in the coming months and years.

This Report is an initial step in the long process ahead for Canadians attempting to find solutions to the problems that it raises. The manner in which we, as a society, respond to these problems will have a significant impact on the lives and deaths of all Canadians and will reflect on Canadian society as a whole for many years to come.

The Committee respectfully submits this Report to the Senate.

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<sup>1</sup> Canadian Medical Association, *Canadian Physicians and Euthanasia* by Frederick H. Lowy, Douglas M. Sawyer and John R. Williams (Ottawa: Canadian Medical Association, 1993).



## Chapter I Overview

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The debate with respect to how we die has not been and cannot be limited to a discussion regarding assisted suicide and euthanasia alone. In attempting to examine these two issues, it immediately became apparent to the Committee that their task involved a great deal more than simply considering the advisability of the legalization of these acts.

### Scope of the Report

The Committee found that it had to examine and become familiar with many of the current health care practices across Canada by medical practitioners, nurses, medical institutions and community services as well as the role that governments play in influencing and directing the provision of such services. A broad spectrum of end-of-life decisions that must be made every day by or on behalf of patients also needed to be considered as part of any discussion on assisted suicide and euthanasia.

These other end-of-life considerations ultimately may or may not influence the way in which each individual thinks about assisted suicide and euthanasia; nonetheless they must be explored in order to ensure that those who engage in future debate are fully informed of the wide ramifications of the issues. An examination of the availability and quality of palliative care, pain control and sedation practices, and advance directives are some examples of the areas that must first be considered.

The division of legislative powers affected the scope of the Report. Some of the issues discussed herein concern criminal law matters, while others deal primarily with health care. Under section 91(27) of the *Constitution Act, 1867*, the Parliament of Canada has exclusive jurisdiction over criminal law and procedure. The provincial legislatures, on the other hand, have jurisdiction over the administration of justice, pursuant to section 92(14). This means that the Parliament of Canada defines what constitutes a criminal offence but the criminal law is then administered by the provinces and the decisions to investigate, charge and prosecute offences are matters of provincial policy. Provincial crown prosecutors are given discretion in these areas.

Health is primarily a matter of provincial jurisdiction as a local or private matter under section 92(16); in addition, authority over hospitals and the regulation of the medical

## Overview

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profession are granted to the provinces pursuant to sections 92(7) and 92(13) of the *Constitution*.

Given the nature of the subject being examined, there were instances in which the Committee, in dealing with matters falling primarily within the federal Parliament's jurisdiction under the *Constitution*, had to consider overlapping provincial aspects of the issues as well in order to make useful recommendations and suggestions.

The Committee's study was also limited in other ways. There were aspects of the various issues that the Committee was not able to examine in any depth: the treatment of persons in persistent vegetative states (PVS), severely disabled newborns and other situations present unique problems. These raise difficult questions that require further consideration. As only a few witnesses made occasional references to these types of cases, the Committee believed that the extremely complex issues they raised required greater clarification and study than the Committee could undertake at this time.

## Background

Some of the witnesses offered their reasons as to why the issues surrounding death and dying have only recently received a considerable amount of public attention. The Committee felt that some of these should be addressed in order to provide the context within which the various issues dealt with in the Report were considered.

### *a) The Canadian Charter of Rights and Freedoms*

*The Canadian Charter of Rights and Freedoms*, which came into force on April 17, 1982, has considerably altered the legal and judicial fabric of the country. The *Charter* guarantees fundamental freedoms (press, religion, expression, association), democratic rights, mobility rights, legal rights, equality rights and language rights. Since the advent of the *Charter*, the Supreme Court of Canada has handed down more than 250 decisions. If a law is challenged and found by a court to infringe on any constitutionally protected rights and freedoms, that court will declare the law under consideration to be of no force and effect. Thus, the *Charter* provides Canadians with a mechanism whereby individuals can challenge government action.

Rights and freedoms are not absolute, they can be restricted according to Section 1 of the *Charter* but only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. The decisions of the Supreme Court of Canada indicate that it has maintained an equilibrium between rights and the limitations that may be imposed on them.

The *Charter* also protects societal values, such as liberty, equality, security, life, personal autonomy and the common good. It has significantly influenced the manner in which Canadians perceive those rights and values.

The *Charter* has greatly contributed to the trend toward individual rights. Indeed, it protects the rights of individuals to make their own decisions and maintain their own views, however radically their opinions may differ from those held by others. Some have

attempted to argue that such constitutionally entrenched rights and freedoms include the right to make certain decisions with respect to death and dying. For instance, Sue Rodriguez utilized the *Charter* in her challenge to the assisted suicide provisions of the *Criminal Code*.

*b) Technological progress*

With the advances in modern technology and innovative medical treatments, human beings are now capable of prolonging life and postponing death. While many people have benefitted from these changes, technological progress in medicine has at the same time raised complex new questions to which the answers are not obvious. Patients, their families and medical practitioners must decide if a patient dying of cancer who goes into cardiac arrest should be resuscitated and whether that same patient should be given antibiotics if he or she contracts pneumonia. Today, when so much can be done, there are many situations that raise ethical questions of what should be done.

In this regard, Ms. Marian Chapman, Chair of the Ottawa-Carleton Council on Aging and a retired professor of family medicine, testified that:

The evolution of medical technology to maintain life and its availability for use in the care of the individual has created a new context within which the dying process must be assessed.

*Chapman 32:54<sup>2</sup>*

Prof. Edward Keyserlingk, who teaches bioethical law and medicine at McGill University, expressed the problem in the following terms:

Technology has put us in this position. People used to die. Now we have great trouble letting people die. It is not because of ill will, it is simply because people are increasingly good at what they do. One can maintain a person for a very long time beyond the point where most people think it reasonable.

*Keyserlingk 1:47*

*c) Attitudes toward death*

Some medical professionals seem to view death as a battle to be fought against at all costs. Dr. Elizabeth Latimer, who is presently the director of palliative care at Hamilton Civic Hospitals, expressed her views about the present day perception of dying by the medical profession:

<sup>2</sup> Refers to the issue of the *Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide* and the page number. Complete information regarding witnesses is found in Appendix A.

## Overview

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Our current medical profession views death as an enemy. In this century we have come to view our mandate to be to overcome death. Combined with this, doctors are also usually action-oriented individuals. We feel a sense of failure when we are not able to cure someone. This sense of failure causes us to distance ourselves from the dying in a way that is not effective for them or helpful in their case.

*Latimer 4:8*

Prof. Brian Mishara, who teaches psychology at the Université du Québec à Montreal and founding president of Suicide-Action Montréal, shared this view:

Some physicians feel that their goal is to cure illness, and it is a personal defeat when the patient dies.

*Mishara 2:36*

This attitude on the part of some medical professionals has resulted in many individuals fearing the process of dying. Some witnesses testified that they do not want their lives prolonged needlessly by artificial and intrusive measures when they become terminally ill. They want to be permitted to die peacefully.

Virtually none of the witnesses suggested that life should be prolonged needlessly. Indeed, most of them were of the view that there are many situations in which certain medical interventions are no longer appropriate. For instance, Dr. James McGregor of the Ontario Palliative Care Association explained:

There needs to be careful and appropriate consideration of the clinical context and, with consistency and planning around the goals and wishes of the patient, non-initiation and cessation of life-prolonging treatments may be part of palliative care. The burdens of treatments at times may outweigh their benefit for the patient. In such situations, non-initiation or cessation of futile treatment improves quality of life and relieves suffering.

*McGregor 4:54*

Dr. Balfour Mount, founding Director of the Royal Victoria Hospital Palliative Care Service and professor of palliative care medicine at McGill University, testified:

Withholding and withdrawing life-prolonging treatment at the patient's wishes is part of palliative care.

*Mount 5:30*

### *d) Settings for death*

In the past, most people died at home in familiar, comforting surroundings in the company of family and friends and without aggressive treatment and life-support. At present, it is becoming more and more common for people to die in the sterile setting of a hospital surrounded by strangers and medical equipment, rather than by loved ones. Dr. Robert Elgie, Director of the Health Law Institute at Dalhousie, commented:



Since the turn of the century, there has also been a dramatic shift in the places where people die. Sixty years ago, the vast majority of deaths occurred at home. It is now estimated that close to 75 per cent of all deaths will occur in hospitals or long-term institutions.

*Elgie 20:56*

Dr. Latimer makes a similar point:

In Canada, as in any country like ours, natural death has been removed from view into hospitals and institutions. Consequently, a lot of young people growing up have never seen anyone die and they do not know what that can look like. That can compound some of the fearfulness.

*Latimer 4:14*

Ms. Angèle St. Germain, a Registered Nurse from Montreal, testified that:

Barely twenty something per cent of people die at home. Death has been institutionalized with all that this involves...They [families] do not have the necessary information to realize that they can be close to their loved ones.

*St. Germain 9:24*

While many witnesses referred to the institutionalization of death, palliative care addresses this problem to some extent by placing more emphasis on human relationships and ensuring that patients are not isolated from the community. To this end, many hospitals have established palliative care units. Also, with the development of palliative care there seems to be increased possibilities for persons to die in their home.

*e) Attitudes towards physicians and patients' rights*

Some witnesses pointed out that, in the past, there has been an assumption within the doctor/patient relationship that the physician knew what was in the best interests of the patient. As a result, patients seldom requested any information other than what he or she had already been provided by the physician. Furthermore, it was only in the rarest cases that the patient refused to consent to a medical procedure and, more often than not, such consent was considered irrelevant in any case. Ms. Ann Mullens, who received the Atkinson Fellowship in Public Policy in 1994 to study assisted suicide and euthanasia, informed the Committee:

That phrase, "the best interests of the patient", should cause us concern; and we should be wary of it. In 1960, when doctors were surveyed in the U.S., 80 per cent believed it was not in the best interests of the patient to tell them they had cancer...The danger lies in paternalism, in telling people we know what is best for them, whether we like it or not. The danger comes from not putting the power in the hands of people or at least having a shared responsibility.

*Mullens 30:8*

There has been significant movement away from this paternalistic approach to health care in North America. Patients are more frequently asserting their right to make health care decisions for themselves. The more traditional attitudes of the medical profession are now being challenged by some as more patients demand to be given full rights and

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responsibilities in this regard. Dr. Paul Landry, of l'Association des Hôpitaux du Québec, expressed his view in the following manner:

We also mentioned that it was important to have a new approach in relations between therapists and patients in which the paternalism of yesterday is gone and relations between patients and caregivers are now much more consensual.

*Landry 19:33*

Moreover, health care professionals are increasingly recognizing the importance of individual choice and personal responsibility in the area of health care. Since, and perhaps because of, the civil rights movement both with respect to race and gender in the 1960s, "rights-talk" has entered into and informed the discussion of death and dying. Many people now speak of a "right" to refuse treatment or a "right" to die. In this connection, Dr. Elgie had this to say:

There are a number of reasons for this increased interest, or at least increased awareness, of the issues. There is an increasing recognition by patients of their autonomy and their right to self-determination with respect to decisions regarding what shall or shall not be done for their bodies. The 1970s reinforced this with the legal acceptance of a new philosophy about informed consent and patients are, accordingly, becoming better consumers.

*Elgie 20:55*

### *f) Changing demographics*

Many witnesses indicated that the increasing average age in Canada places, and will likely continue to place, significant demands on the health care system. Professor Barney Sneiderman, who teaches law and bio-medical ethics at the University of Manitoba, stated:

I agree with the sentiment you have expressed as to how we go about creating a health care system for the twenty-first century, particularly given the fact of an increasingly aging population, which will bring its own pressures to bear.

*Sneiderman 6:72*

Dr. Landry offered this view:

The aging of the population is of course a phenomenon which preoccupies and concerns us to the highest degree. Primarily the emergence or predominance of degenerative diseases, chronic diseases, including the increase in the incidence of cancer, the appearance of AIDS, which was mentioned earlier and Alzheimer's, very often raise the questions here concerning us with the respect to quality of life.

*Landry 19:33*

Furthermore, a new demographic group - persons with HIV/AIDS - has emerged. Dr. Michel Morissette, a clinical physician and professor at Laval University, informed the Committee that many members of this group have been very active in promoting their right to take control of their health care and have brought their special needs and desires to the debate. He testified:

Many AIDS victims are young people, generally well informed and concerned about their independence and self-determination. These patients want to be involved in the process of making decisions that affect them and this gives rise to a new dynamic in the doctor-patient relationship, although a certain generation of physicians is not at all familiar with this.

*Morissette 32:5*

Russel Armstrong, a member of the Canadian AIDS Society which is a national coalition of community-based organizations stated:

As some of you may be aware, AIDS is estimated to have caused 14,000 deaths in Canada, to date. In several ways, AIDS is different from other terminal diseases. During the previous presentations, senators addressed the issue of the stigma associated with this disease, as opposed to other diseases which are not. To date HIV/AIDS has disproportionately affected marginalized groups, specifically gay and bisexual men, although, today, in almost all Canadian communities are people living with HIV/AIDS...In many ways AIDS is a disease of the modern age. In the relatively short period of time since it first emerged, AIDS has become one of the most talked about and studied diseases of our century. It has an active community-based movement associated with it, a movement that has worked to heighten awareness of the disease, to provide care, support and advocacy, and also to ensure that the rights and dignity of those who live with the disease are respected.

*Armstrong 12:39-40*

A convergence of events involving judicial decisions, changes in medical technology, evolving attitudes, debate within professional organizations, *Charter* arguments, and the development of palliative care has broadened the scope of this study beyond assisted suicide and euthanasia. The Committee realized that terms would have to be defined, and full discussions on palliative care, pain control, and withholding and withdrawing treatment should occur before any discussions with respect to assisted suicide and euthanasia could take place. These matters are considered in the following chapters.





## Chapter II

# Terminology

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The terminology used in Canada and abroad, in referring to questions of death and dying, is wide-ranging and diverse. Throughout the course of its hearings, the Committee often heard the same terms being defined in various ways. However, the differences in the definitions are seldom based on the literal meaning of the terms; this is generally not disputed. The disagreement is essentially with respect to the moral significance of the words. In fact, the definitions of the terms may and often are developed in order to argue a specific moral or ethical perspective with respect to the acts in question. For instance, most witnesses argued that acts of withholding or withdrawing a life-support system are fundamentally distinct from acts of euthanasia because, in their view, withholding or withdrawing life saving treatment is, in effect, allowing natural death to occur; while an act of euthanasia is the cause of death. Other witnesses argued that withholding and withdrawing actions are forms of euthanasia because, morally, these are as active as lethal injections.

Dr. Paul V. Adams of Manitoba Physicians for Life, describes what many view as the fundamental moral or ethical difference between acts of withholding and withdrawing and acts of euthanasia:

There is an essential difference between causing one to die, which is euthanasia, helping one to die, which would be assisted suicide, and allowing natural death to occur, which I referred to as withholding or withdrawing treatment. Frequently, there is confusion regarding the third category, that is, allowing natural death to occur when death is inevitable, and there is no clinical or ethical reason to intervene. This is not euthanasia. It is both morally and ethically acceptable and it should continue to be legally acceptable.

*Manitoba Physicians for Life 18:40*

Dr. McGregor shared this view:

Although cessation and non-initiation of treatment have been considered as “passive euthanasia”, in fact, we believe they simply represent non-interventionist actions, allowing the natural history of the illness to progress. These acts are not considered to be euthanasia or assisted suicide.

*McGregor 4:54*

And Dr. Keyserlingk explained that:

Legally, this omission under these circumstances [not providing life support when it is refused by a competent patient or when treatment has become futile for an incompetent patient] would simply be good medical care.

*Keyserlingk 1:28*

Professor Arthur Schafer, an ethical expert at the Centre for Professional and Applied Ethics at the University of Manitoba, stated:

Withholding or withdrawing life-saving medical care, “pulling the plug”, used to be called “passive euthanasia”. However, as you reread the briefs of many of my other colleagues, you will see that none of them still uses the term “euthanasia” for these very widespread social practices. Indeed, tens of thousands of Canadians die every year by what would have been called “passive euthanasia” and what would have been condemned by church groups and by individuals as an alarming, dangerous, negative development as recently as 12, 15 years ago.

*Schafer 18:122*

Another example involves the moral distinction or lack thereof between acts of euthanasia and acts of assistance in suicide. Some witnesses argued that, morally, assisted suicide is identical to euthanasia, as did Dr. Margaret Somerville, Director of the Centre for Medicine, Ethics and Law at McGill University:

In defining euthanasia, we need to look as well at whether physician-assisted suicide is different from euthanasia. I would propose to you that it is not.

*Somerville 6:7*

Dr. Keyserlingk held the same position:

Is there anything of moral and legal significance that is different between assisting the suicide of a patient who is still able to take the glass and drink it and the patient who is beyond that because of no longer having the physical ability but who wants to be killed and is doing it with an overdose? Is there anything of moral and legal significance that establishes the real difference there? I tend to think that it is going to be a hard case to make because in both cases it is the patient’s wish. In both cases, the argument can be made on the basis of self determination and people’s right to choose their manner and time of dying. The manner is slightly different, but in both cases it is the patient’s wish, and in both cases we can get very close.

*Keyserlingk 1: 55-56*

Dr. Douglas Kinsella, a professor and Director of Bioethics in the Faculty of Medicine at the University of Calgary and Dr. Marja Verhoef, an assistant professor in the Department of Community Health Sciences at the same university, both conducted a survey with respect to physicians’ opinions on assisted suicide and active euthanasia. Interestingly, they held different views in comparing these two acts. Dr. Kinsella concurred with Dr. Somerville and Dr. Keyserlingk. He argued that the only difference lies in who is present at the time of death:

From the moral perspective of the physician, there is in fact no essential difference between active euthanasia and assisted suicide...In the actual commission of assisted suicide, it should be noted that the only significant difference from active euthanasia is that the physician is usually absent at the moment of the suicide.

*Kinsella 16:6*

Dr. Verhoef maintained the position that assisted suicide and euthanasia are two fundamentally different actions on the basis that each action results in a change in the power structure. Unlike euthanasia, an assisted suicide places more control in the hands of the person who wishes death:

Euthanasia is a deliberate termination of the life of a patient by someone else at the patient's request. Assisted suicide is the deliberate provision of the means for suicide by someone else at the request of the patient. In the Canadian context, this other person is usually considered to be the physician. In assisted suicide, the final act is solely the patient's, the physician being only indirectly involved. Conversely, with respect to euthanasia the physician provides the means and carries out the final act, which greatly amplifies the physician's power over the patient. The balance of power between doctor and patient in assisted suicide is more equal.

*Verhoef 18:79*

As the foregoing excerpts indicate, there is simply no consensus on what terms to use or how to define them due to the divergent views on the moral and ethical significance of the various forms of conduct. Thus, in order to ensure consistency and to avoid any misunderstanding, the terms used throughout this Report are set out below along with the meaning ascribed to each. In defining these terms, the Committee has opted for a literal meaning that appears to be undisputed and widely accepted. First, the major activities surrounding death and dying were divided into categories and these were labelled. The Committee then became aware that some of these activities may be qualified in various ways. Therefore, these qualifiers have also been defined.

### Qualifiers

Some of the activities described below may be performed on or by competent or incompetent individuals and may be involuntary, nonvoluntary, or voluntary. Therefore, the Committee has defined the following qualifying terms:

- *competent*
- *incompetent*
- *involuntary*
- *nonvoluntary*
- *voluntary*.

**“Competent”** means capable of understanding the nature and consequences of the decision to be made and capable of communicating this decision.

## **Terminology**

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**“Incompetent”** means not capable of understanding the nature and consequences of the decision to be made and/or not capable of communicating this decision.

**“Involuntary”** means done *against* the wishes of a competent individual or a valid advance directive.

**“Non-voluntary”** means done *without the knowledge* of the wishes of a competent individual or of an incompetent individual.

**“Voluntary”** means done *in accordance with* the wishes of a competent individual or a valid advance directive.

## **Activities**

For the purposes of this Report, and hopefully for the ensuing debate as well, the Committee has defined the following activities:

- *palliative care*
- *total sedation*
- *treatment aimed at the alleviation of suffering that may shorten life*
- *the withholding of life-sustaining treatment*
- *the withdrawal of life-sustaining treatment*
- *assisted suicide*
- *euthanasia.*

**“Palliative care”** is care aimed at alleviating suffering - physical, emotional, psychosocial, or spiritual - rather than curing. It is concerned with the comfort of the suffering individual.

**“Total sedation”** is the practice of rendering a person totally unconscious through the administration of drugs without potentially shortening life.

**“Treatment aimed at the alleviation of suffering that may shorten life”** is the administration of sufficient amounts of drugs to control suffering even though this may shorten life.

**“Withholding of life-sustaining treatment”** is not starting treatment that has the potential to sustain the life of a patient.

**“Withdrawal of life-sustaining treatment”** is stopping treatment that has the potential to sustain the life of a patient.

**“Assisted suicide”** is the act of intentionally killing oneself with the assistance of another who provides the knowledge, means, or both.

**“Euthanasia”** is a deliberate act undertaken by one person with the intention of ending the life of another person to relieve that person’s suffering where that act is the cause of death.



## Miscellaneous Terms

Finally, several miscellaneous terms were used throughout the Report and these have also been defined including advance directives, surrogate decision-maker, substituted judgment, best interests judgment, futile treatment, and free and informed consent.

**“Advance directive”**, referred to as mandate in the *Quebec Civil Code*, and also commonly known as a living will, is a document executed by a competent individual concerning health care decisions to be made in the event that the individual becomes incompetent to make such decisions. Advance directives can be divided into two categories - instruction directives and proxy directives. The latter are also known as durable powers of attorney for health care. In an instruction directive, an individual sets out *what or how health care decisions are to be made* in the event that he or she becomes incompetent. In a proxy directive, an individual sets out *who is to make health care decisions* in the event that he or she becomes incompetent. A valid advance directive is one completed according to the requirements set out in the relevant legislation. Throughout this Report, when the expression advance directive is used, validity is assumed unless otherwise indicated.

**“Surrogate decision-maker”** is someone who is authorized by law or by a person, through a power of attorney, for example, or is appointed by a court to make treatment decisions on behalf of an incapable person.

**“Substituted judgment”** refers to a judgment made by a surrogate decision-maker on behalf of an incompetent individual according to what the surrogate decision-maker believes would be the wishes of the incompetent individual were the individual competent.

**“Best interests judgment”** is a judgment made by a surrogate decision-maker on behalf of an incompetent individual according to what that surrogate decision-maker considers to be in the incompetent individual’s best interests.

**“Futile Treatment”** is treatment that in the opinion of the health care team will be completely ineffective. This term does not include treatment that may be effective but whose results are deemed undesirable.

**“Free and informed consent”** means the voluntary agreement by a person who in the possession and exercise of sufficient mental capacity, as defined by an appropriate medical professional, makes an intelligent choice as to treatment options. It supposes knowledge about the consequences of having or not having the treatment and about possible alternatives. The consent must be free from coercion, duress and mistake.



## Chapter III

### Palliative Care

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The Committee began its hearings with the expectation that the large majority of its time would be spent on the ethical, social, legal and medical issues that have come to be associated with assisted suicide and euthanasia. However, at the outset of the hearings, it became apparent that a major and unanticipated issue was the question of alternatives to assisted suicide and euthanasia. Some witnesses told the Committee that people need better support during the dying process and in dealing with the circumstances surrounding death and that palliative care could address many of these needs. Dr. Neil Macdonald, of the Clinical Research Institute of Montreal, explained:

One cannot in a moral society consider terminating a fellow citizen's life, if that citizen is suffering because of lack of access to good palliative care. Regardless of one's views on euthanasia, one must concur that, as a first principle, impeccable care for dying citizens must be ensured.

*Macdonald 22:26*

The Committee heard a significant amount of testimony with respect to both the benefits of palliative care and also the limitations and restrictions of the present day palliative care services offered in Canada. For this reason, a background paper was prepared setting out the history and present state of palliative care services across Canada. This supplemental information is included in Appendix M of this Report.

Although the concept is not new, modern palliative care began in Great Britain in 1967 when Dame Cicely Saunders established the hospice movement. Over the past twenty-five years, Canada has seen a remarkable development in the availability of palliative care services, from its beginning in the 1970s to a network of providers throughout Canada in the 1990s. In 1991, a national organization, the Canadian Palliative Care Association, was founded.

A generation ago, most Canadians dealt with their family physician, who knew the patient's family and social environment intimately. As medical care became more specialized and institutionalized, there was a tendency to focus on the disease rather than the patient. Palliative care reflects, in part, a shift back to patient centred medical care. As Dr. James Gordon, a Quebec neurologist said:

## Palliative Care

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I give my patients palliative care at the same time as I am giving them active, aggressive, curative treatment, most of the time. In that way people will come to understand that they will get palliative care from their doctors. That means kindness, decency, being treated as people. It does not mean a specific protocol for dealing with a specific kind of problem, although that may be included in your training.

*Gordon 27:21*

Palliative care is defined as *care aimed at alleviating suffering - physical, emotional, psychosocial, or spiritual - rather than curing. It is concerned with the comfort of the individual.* Dr. Latimer described the objectives of palliative care as follows:

The goals of palliative care are excellence in physical care for the patient and excellence in the support of counselling for the family and the patient. Palliative care will seek to enhance the quality of life for the patient and their family.

*Latimer 4:6*

Palliative care is interdisciplinary and is centred around the person rather than the disease. Dr. McGregor described it as follows:

Included in that interdisciplinary team are volunteers - lay people - who provide hands-on bedside care; emotional and spiritual support, and some basic care of the individual patient. Also, we include the family and teach the family how to become involved in caring for the patient...Not only professionals can provide palliative care...Palliative care is not the domain of any profession.

*McGregor 4:65*

Dr. Mount pointed out that the benefits of palliative are recognized worldwide:

The World Health Organization states that palliative care affirms life and regards dying as a normal process; it neither hastens nor postpones death; it provides relief from pain and suffering; it integrates the psychological and spiritual aspects of the patient.

*Mount 5:30*

In Canada, palliative care is usually provided by a specialized team located within an acute or long-term care facility, in a free-standing hospice, or in the home. These services are funded in a wide variety of ways, such as health care facility global budgets, home care programs, fee-for-service under provincial health insurance plans, salaried positions, and private donations.

## Points of View of Witnesses

Palliative care was endorsed by all the witnesses who raised the issue before the Committee. The individuals working in the field, whether health care professionals or volunteers, believe that palliative care enhances the quality of health care services and improves the care of the dying. The Committee heard testimony about situations in which palliative care immeasurably improved the last days and months of dying individuals. Dr. McGregor and Dr. Latimer shared their thoughts based on their own experience in the field:



I have had this happen personally in my experience practising palliative medicine. The patient, in the final stages of living, has gone on to find new meaning out of the darkness of despair through the shared journey of exploration of meaning and reinforcement of their value as individuals.

*McGregor 4:54*

Palliative care promotes opportunities for healing in relationships and for forgiveness in families. There is not a waiting time for death, but rather an active and positive opportunity to live.

*Latimer 4:6*

The Committee was consistently told that palliative care is presently available to only a small percentage of dying individuals and that it is unevenly distributed across Canada. For example, Dr. Latimer stated that organized palliative care is not available throughout Canada to all Canadians.<sup>3</sup>

Dr. McGregor also expressed this viewpoint:

It is society's responsibility through government, health care planners, professional organizations, and health professions to provide the resources to ensure a system of intensive caring for dying patients and their families. This necessitates the development of the field of palliative care to ensure that the appropriate expertise is widely and readily available as well as accessible to all...It is unfortunate that Canadians continue to die in pain because this expertise is not available to them.

*McGregor 4:53*

Palliative care facilities have traditionally focused on cancer patients and as a result patients with other medical problems, such as amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), Alzheimer's disease, end-stage renal or respiratory or cardiac disease, have had difficulty in obtaining access to palliative care.

Many witnesses told the Committee that palliative care facilities, programs and staff suffer from inadequate funding. The lack of a coordinated approach to the provision of services in many provinces and territories makes it difficult to assess or meet funding needs. In addition, restrictions on physician reimbursement have limited access to palliative care. Dr. Mount described the situation:

In most provinces, there is an absence of secure, accepted funding mechanisms...One of my colleagues, a young family physician with a Masters degree in epidemiology and a fine mind and burning interest in palliative care, moved to Halifax and depressed me by not going into palliative care. I said to him, "Why do you not do palliative care?" He said, "Because I have to feed my family." There are not secure funding mechanisms in most provinces - Quebec is an exception - to fund palliative care physicians.

*Mount 5:31*

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Latimer 4:12.

Another major constraint is the limited number of health care professionals currently being trained in palliative care in Canada. For example, there are no official palliative care specialty programs for health care professionals:

An official program in training must await recognition of palliative medicine in Canada as a specialty. Forty physicians come through our program each year one way or another. That sounds terrific. By "come through", I mean they may be there for a week to as long as a year. At present there are two funded fellowship programs, one in Ottawa and one in Edmonton.

*Mount 5:38*

In addition, health care professional students receive very little training in palliative care as part of their basic education. Dr. Macdonald presented the Committee with the results of a 1994 survey on palliative care training in Canadian medical schools, conducted by the Canadian Palliative Care Education Group, a committee of the Canadian Society of Palliative Care Physicians:

I wish to put the results of our 1994 survey before the Senate committee because it is germane to your discussions. Answers from all 16 of our schools are included here. First, we asked: Is there a formal palliative care course in your faculty? The answer was "no" in all 16 cases.

*Macdonald 22:24*

Dr. Macdonald also told the Committee that only four of the sixteen medical schools have increased formal teaching of palliative care in the past two years. He concluded that:

As reflected in the opinion of colleagues designated by their deans as responsible for palliative care education in their faculties, the current status of education on pain and palliative care is far from satisfactory.

*Macdonald 22:16*

Dr. Harvey Chochinov, a psychiatrist from the Manitoba Cancer Treatment and Research Foundation, also referred to the lack of education in this area:

Hospitals need not demonstrate proficiency in palliative or pain management in order to operate; medical schools need not provide more than beyond minimal training in this area for accreditation; and physicians are not required to demonstrate competence or proficiency in this area of medicine in order to gain licensure in this country. Death and dying is the least-studied phase of the human life cycle and receives the least amount of support from medical research funding agencies.

*Chochinov 17:12*

Dr. Macdonald expressed his view as to why education in palliative care is critical in the field of medicine:

Palliative care is not a single issue topic, but rather presents to undergraduate students a method of whole patient care that will certainly benefit the students in specific technical areas such as the proper use of analgesics but, more importantly, should influence their overall approach to medical care.

*Macdonald, 22:28*

Many witnesses pointed out that if palliative care is to become more effective at meeting the needs of dying patients, more research is required into pain control methods. According to Dr. Latimer:

We use opioid analgesics, pain-relieving narcotic drugs, very well in palliative care, but we have reached our saturation point with what we can do with those drugs. There are two or three pain syndromes that are particularly difficult for us to treat, nerve pain, bone pain, and pain that is largely comprised of suffering in the psychological sphere.

We have not put serious research money in Canada into addressing either physical pain relief or the relief of suffering. If we were to be serious, those would be the two paths that we need to put serious research money into.

*Latimer 4:16*

Another concern raised by some of the witnesses was that not all people facing death want palliative care. While palliative care is beneficial for the vast majority of people who are dying, these witnesses said that it is not always the appropriate response for everyone; it will not always be the solution to the problems of those facing death. Mr. Arn Schilder, of the British Columbia Persons with Aids, described the ineffectiveness of palliative care in his personal situation:

I do not see a great deal of dignity in being anaesthetized beyond being *compos mentis* in a palliative care ward. I would rather look at my Maker with open eyes and make a decision...Palliative care may not be for me because pain management may not be possible. I am one of those unusual cases...Because of my personal situation, the drugs that could treat opportunistic infections are not going to be available to me. I would personally want to have the choice. The opportunity to die in palliative care would be very nice...However, I do not necessarily want to go into a palliative care facility. I want to die at home. I want to choose the time when it is right. I do not want to lose my mental capacities. That happens in a palliative care environment because you are heavily anaesthetized.

*Schilder 16:25-26*

In addition, some witnesses said that not all suffering involves physical pain. Dr. Scott Wallace, of British Columbia, told the Committee:

The process of dying may involve some of the most miserable and distressing sensations known to man...Accompanying these debilitating and demoralizing symptoms is the loss of dignity, self-esteem and privacy which comes from depending entirely on others to manage each and every aspect of one's bodily and mental needs, 24 hours a day.

*Wallace 15:86*

Several witnesses noted that AIDS patients are a special group and palliative care programs, in order to be effective for them, must be tailored to their particular needs. Dr. Morissette, a clinical physician working with 85 HIV/AIDS patients, had this to say on the issue:

AIDS is a disease that stigmatizes its sufferers, causes them to be ostracized and opens the door to discrimination and violation of individual rights, if not collective rights as well...

Many AIDS victims are young people, generally well informed and concerned about their independence and self-determination. These patients want to be involved in the process of making decisions that affect them...

We must also note the difficult deaths faced by these individuals, both physically...and psychologically, socially and spiritually (isolation, abandonment by their family, guilt, fear of suffering and dying, of death and the hereafter...).

The symbolic burden of AIDS, in particular because of the issues relating to sexuality and social marginalization, casts this disease in a particular light.

*Morissette 32:5-6*

Sister Agathe Coté described how Maison Marc Simon, a hospice for HIV and AIDS victims in Quebec City, addresses the special needs of these individuals:

Maison Marc Simon is not a place of death, but rather a place of life, where people with HIV and AIDS are accepted as they are and their differences are respected. Emphasis is placed more on the quality of life than on the number of days one has left to live.

*Coté 32:11*

Although the recognition of palliative care as an essential service is a recent phenomenon, health care professionals and families have always provided palliative care on a personal and informal basis. For example, nurses have long provided continuing care and comfort even when a cure was no longer possible. The Canadian Nurses Association explained:

Regardless of any discussion of euthanasia, nurses support the need to provide palliative care. They feel especially strongly about this subject because when there are no more cures to offer, there is still nursing care, and it needs to be the best. The CNA believes palliative care is an essential health care service.

*Canadian Nurses Association, 19:6*

Witnesses also referred to the shift that is evident in many parts of Canada from institutional care to home care. Dr. Ferguson, from the New Brunswick Extra-Mural Hospital, informed the Committee:

In many provinces, homecare has been developed more or less as a project or program. With us, it is part of the system. We like to think that we have a different approach to it, and we are encouraging it to be used more effectively. That is our objective, at any rate.

*Ferguson 20:53*



He describes the many benefits of providing palliative care in the home:

Dying at home can provide the opportunity for quiet, privacy, dignity, and family closeness. That may make death easier for the patient, and provide more consolation for the bereaved. Assuming a stable and caring home environment exists, emotional and physical comfort is often greatest at home with family, friends and pets nearby. Surveys of surviving relatives of deceased patients show that the patients and the survivors were very satisfied with the care we provided for the deceased.

*Ferguson 20:49*

Some witnesses said it is neither appropriate nor even possible for everyone and it can sometimes place an overwhelming burden on those in the home providing the care. Ms. Eleanor Ross, President of the Canadian Nurses Association, testified:

When we advocate home palliative care, we are not advocating that it be put onto the family. That is why when we talk about the palliative care team we talk about the need to support the family. The family not only needs day-to-day support but also breaks and respite care. We advocate that there be those breaks. If we have a long term chronically ill patient we need to organize programs to have someone go into the home to relieve the family so that, for example, they can go on a vacation for a week or two; or to bring the client back into the hospital so that the family can have a break.

*Ross 19:13*

## **Committee Deliberations**

The Committee commends the health care professionals and the many volunteers who work in palliative care in Canada. The programs that have been developed to date in order to care for the dying have improved the quality of the life and death of many Canadians.

The Committee, however, is concerned that the demand for palliative care is still greater than available services. They believe there should be universal access to competent and effective palliative care. It should be integrated with other health care services and, ideally, its availability should not vary substantially from region to region. The Committee urges governments, at all levels, as well as health care planners, providers, and educators to make the development of a comprehensive system of palliative care in Canada a priority.

The Committee believes that national guidelines or standards for palliative care are essential. Although the provision of health care services is a provincial matter, the federal government does have a role to play. Palliative care requires a dynamic federal, provincial and territorial response. The Committee encourages the cooperation among the various levels of government and health care professionals. The division of Health Canada responsible for health protection and promotion could, for example, in cooperation with the provincial ministers of health, as well as health care experts from across the country, encourage the establishment of national palliative care guidelines and standards. This type of initiative was first undertaken by Health and Welfare Canada in 1989 when it issued a pamphlet entitled "Palliative Care Services Guidelines". The Committee was told, however, that these guidelines require updating.

## **Palliative Care**

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The Committee urges governments to consider the most appropriate way of supporting palliative care providers with the objective of encouraging more young professionals to enter the field of palliative care. The Committee feels that the involvement of volunteers in the delivery of palliative care should be increased and supported.

The Committee members are of the opinion that the health care delivery system should ensure that palliative care is also available to all patients with chronic or degenerative illnesses, such as ALS, MS, AIDS, Alzheimer's and other diseases.

As the palliative care delivery structure expands, health care professionals will require more training and resources will be needed for palliative care programs in health care educational institutions. Continuing education should be made available to health care professionals as mandated by their professional governing bodies.

In order to improve public awareness of palliative care and to enhance public support for an expanded palliative care structure, the Committee encourages the federal Minister of Health, in cooperation with the provinces and territories, to sponsor a national information program. The members feel that it is important for Canadians to be informed about what palliative care is, what it can do and where it is available.

The Committee supports home care and community-based care, although it recognizes that home care may not be appropriate for everyone. It can sometimes place overwhelming and unrelenting burdens on the caregiver in the home. For that reason, home care must also be supported by good respite programs. The members are aware that the burden of care has traditionally been borne primarily by women. They believe that respite care can help to ensure that caregivers are not disadvantaged in the workplace because of the demands of caregiving.

## **Recommendations**

**The Committee recommends governments make palliative care programs a top priority in the restructuring of the health care system.**

**The Committee recommends the development and implementation of national guidelines and standards be continued.**

**The Committee recommends the training of health care professionals in all aspects of palliative care be increased.**

**The Committee recommends there be an integrated approach to palliative care. The delivery of care, whether in the home, in hospices or in institutions, with the support of volunteers, must be coordinated to maximize effectiveness. The provision of respite services is an essential component.**

**The Committee recommends research into palliative care, especially pain control and symptom relief, be expanded and improved.**

## Chapter IV

# Pain Control and Sedation Practices

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**I**t is not always the possibility of debilitation and disease that people fear most when they think of their dying but rather the pain and suffering which often accompanies that passage of life. Comprehensive palliative care could address most of the worries of dying patients by providing the best available methods of pain control and that in turn would do much to alleviate their suffering.

Since pain control and sedation of patients are also practised outside the palliative care context, the Committee decided these procedures should be considered in a separate chapter.

Many witnesses repeatedly indicated that pain control techniques are not being adequately used and, often, sufficient medication to control pain is not being provided. Several witnesses suggested this is due to a lack of training and education of medical professionals in the area. Others stated that some medical professionals fear liability if the administration of drugs to control pain results in a hastening of death. Finally, fear of addiction of patients was also offered as a further explanation for the failure to provide adequate pain control in some circumstances. Dr. Macdonald observed the problem in the following terms:

What is required...is an attitudinal change on the part of the medical and administrative leaders, supported by expressed public comment telling educators that incorporation of the principles of palliative medicine in the training of its future physicians is a priority community expectation.

*Macdonald 22:28*

In addition, witnesses pointed out that although physical pain can in most cases be alleviated with adequate pain control, there is a small percentage for whom even the best pain control measures will not completely alleviate their physical distress:

There exists a large number of worst-case scenarios. That is, despite the best palliative care, despite the best treatment and pain management, there exist cases where our worst nightmares and fears are realized.

*Mishara 2:36*

## **Pain Control and Sedation Practices**

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We do have people for whom we are not able to relieve pain. They are few. We call them people with intractable pain problems. They are devastating problems.

*Latimer 4:16*

Medical institutions and medical professionals are following two distinct types of practices with respect to pain control and sedation:

- *treatment aimed at the alleviation of suffering that may shorten life*
- *total sedation*

### **Treatment Aimed at the Alleviation of Suffering that may Shorten Life**

The Committee has defined the provision of treatment aimed at alleviating suffering that may shorten life as *the administration of sufficient amounts of drugs in order to control suffering even though this may shorten life*. Whether the treatment does shorten life will depend upon the dosage provided. Some patients, depending upon the drug, the disease and their own level of tolerance, may require much higher dosages in order to alleviate suffering than other patients. An example of this practice includes giving potentially life-shortening doses of drugs for relief of cancer pain.

### **Legal Status**

The Honourable Allan Rock, Minister of Justice and Attorney General of Canada, informed the Committee that the current legal status of providing such treatment is relatively clear. He testified:

The *Criminal Code* does not require futile treatment, nor does it require capable patients to accept treatment they do not want. Similarly, necessary palliative care which is carried out in accordance with generally accepted medical practice is not prohibited by the Code whether or not this treatment results in the death of the patient.

*Rock 31:17*

The Canadian Bar Association referred specifically to the legal status of terminal sedation as a medical technique to control pain:<sup>4</sup>

One may argue that the *Criminal Code* does not apply to terminal sedation; there is no intent to kill, so the homicide provisions would not apply; similarly, there is no reckless disregard for life, so the provisions of criminal negligence would not appear to apply, as a matter of law. Following this, there would be no issue of prosecutorial discretion.

The policy of the Ontario coroner is illustrative of the practice in this regard. Palliative care that results in death is not considered to be criminal, so long as four conditions are satisfied: (1) the care must be intended solely to relieve suffering; (2) it must be administered in response to suffering or signs of suffering; (3) it must commensurate with that suffering; and (4) it cannot be a

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4 Submission of the Canadian Bar Association, March 1995.



deliberate infliction of death. Documentation is required, and the doses must increase progressively.

There is no precedent in this area. There have never been any legal convictions for providing such treatment and although there are no decided cases on point, a reference was made to the practice of providing potentially life-shortening treatment with the purpose of alleviating suffering in the *Rodriguez* case. The real issue in that case concerned assisted suicide under section 241 of the *Criminal Code*. Mr. Justice Sopinka, writing for the majority of the Supreme Court of Canada, however, drew a legal distinction, based on intention, between the administration of drugs that are likely to hasten death on the one hand and assistance in suicide on the other. Without deciding the issue, by implication he seems to have suggested that if the intention is to alleviate suffering, it is legally permissible to provide treatment notwithstanding that this may hasten death.

The administration of drugs designed for pain control in dosages which the physician knows will hasten death constitutes active contribution to death by any standard. However, the distinction drawn here is one based upon intention — in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death...In my view, distinctions based upon intent are important, and in fact, form the basis of our criminal law. While factually the distinction may, at times, be difficult to draw, legally it is clear.<sup>5</sup>

Despite the fact that there is little doubt that this practice is legal, the Minister of Justice suggested there seems to be some confusion within the medical profession, and the public in general, as to what is legally permissible in this regard:

When is it permissible to keep prescribing morphine when you know within the next six hours it will cause death? The underlying disease will not kill the person, however the treatment for the pain will. At present, that is shrouded in obscurity.

*Rock 31:25*

He explained many would like the law in the area to be clearly set out and simplified and there is support for greater clarification of the issue:

The question arises: Can the *Criminal Code* be made plainer or simpler in these respects? The Law Reform Commission of Canada, in its 1983 report on these issues, called for greater clarification, and others have supported this view.

*Rock 31:17*

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5 *R. v. Rodriguez*, [1993] 3 S.C.R. 519, p. 607.

### Points of View of Witnesses

There was general agreement among the witnesses that providing treatment to alleviate suffering that may hasten death is a practice that occurs quite often in Canada. For example, Professor Schafer, testified:

If we think about it, what the palliative care physician frequently does in giving an adequate dose of painkilling medication is hasten the death of the patient, entirely justifiably in my judgment, and entirely justifiably in the judgment of every one of my philosophical and legal colleagues whose briefs I have read.

*Schafer 18:124*

However, there was some disagreement with respect to how often the drugs provided are actually life shortening. Some witnesses said the incidence is low because doses that would be life shortening in healthy patients are not life shortening in end stage cancer patients, due to the tolerance that develops over time among the latter group of patients. Dr. Macdonald stated:

Another area of confusion is whether or not we are killing the patient with these drugs. That was a subject of correspondence I had with the committee. People think, for example, if we increase the dose of opioids so that a person is stuporous, we may kill the patient if we give them a little more. In my experience, that is highly unlikely to happen. Patients rapidly become tolerant to the respiratory effects of opioids, morphine and like drugs. If we give them a large dosage of a drug, we may sedate the patient but it is unlikely that the patient would die of our drug. They may die of pneumonia or an associated problem which sedation might make more likely to come about, but to die directly of a drug effect is unusual.

*Macdonald 22:32*

Other witnesses indicated the incidence is higher than the foregoing argument suggests because, even in cases where patients have become more tolerant to the effects of certain types of medication, the doses given are life shortening. For instance, Russel Ogden, who conducted research on cases of assisted suicide and euthanasia, particularly with respect to persons with AIDs or HIV, also describes the case of a doctor who admitted to having provided morphine injections to his terminally ill father. The doctor stated he was aware of the fact that it may have hastened death.<sup>6</sup> The British Columbia College of Physicians and Surgeons decided the doctor simply provided his father with quality palliative care and did nothing wrong since treatment that may coincidentally hasten death is neither illegal or unethical.

Many witnesses testified that health care professionals quite frequently do not provide patients with sufficient pain medication. One reason for this is the concern that the patients

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6 Russel Ogden, "The Right to Die: A Policy Proposal for Euthanasia and Aid in Dying" (1994) XX: 1 *Canadian Public Policy* p. 4.

will become addicted to the medication. As both Ms. Carol Rees of Action Life, and Ms. Jakki Jeffs of Alliance for Life, informed the Committee:

The higher effective dosages of morphine required to control pain in cancer patients are withheld from patients because health care workers fear that administering them could hasten the patient's death or result in addiction.

*Action Life 8:11*

I believe fear of addiction to morphine, either by the medical practitioner himself or by the patient, is another reason why morphine is not used as it ought to be. Again, research shows that .04 per cent of patients treated with morphine become addicted. Let us educate our public and our doctors to effective pain management.

*Alliance For Life 8:44*

Reverend James Dickey, in sharing his experiences based on his work as a pastoral minister, related an anecdote that supported this view. He told the Committee of an 83-year-old man who was in agony yet the doctors refused to administer pain medication because they were afraid that he would become addicted.<sup>7</sup>

A more commonly cited reason for why some health care professionals refuse to provide sufficient pain medication is the belief that doses sufficient to control the pain would be potentially life shortening and, thus, liability may ensue if such medication is provided. Ms. Monique Coupal, of the *Fédération québécoise des centres d'hébergement et de soins de longue durée*, expressed this viewpoint:

We find it surprising, even unconscionable, that in 1995 some physicians still hesitate for all sorts of reasons, to prescribe sufficient doses of medication to ease what we consider needless suffering. They do this out of fear either of accelerating the dying process or even, in some cases, out of fear of making a terminally ill patient dependant on a drug.

*Coupal 32:39*

Ms. Patricia Rodney, a registered nurse from British Columbia, illustrated the reluctance of some health care professionals to provide analgesics to alleviate pain if it may result in a hastening of death. She related a personal incident of a patient who was dying of a stroke and was in pain. The family was distressed and requested that the doctors provide analgesia and sedation. The nursing staff was also concerned and asked the physician in charge to administer some morphine. The physician was reluctant but eventually ordered one of the nurses to administer an analgesic. The patient died soon after but the nurse was not concerned about this because she knew this was inevitable. She was, however, concerned when the physician said "Well, I guess you killed that patient, didn't you". Ms. Rodney used this example to demonstrate that:

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7 Dickey 8:61.

## **Pain Control and Sedation Practices**

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The game playing and behaviours that revolve around issues such as analgesics can be very complex and very pervasive...Within hospitals and health care facilities we have an organizational context that results in conflict, fragmented communications, and poor decision-making. It is not the fault of doctors or of nurses; it is the fault of our entire system.

*Rodney 15:129*

In other instances, the lack of training of medical professionals in this area is a fundamental reason for the underutilization of pain control techniques. Dr. Robert Pankratz, President of Canadian Physicians for Life, testified:

We try to educate our fellow physicians. Perhaps 50 per cent of the physicians that I have daily contact with are inadequately informed as to the modern techniques and their patients are suffering as a result.

*Pankratz 14:31*

Dr. Kinsella also expressed this view:

It is quite clear that there has been this almost bizarre ethic of behaviour within the medical profession in terms of its ability to come to grips with the control of pain, control of nausea, control of vomiting, control of all those things which occur in some but not all patients who are dying. It is a deficiency in the educational system. There is absolutely no question about that. If we are going to do anything about it, we must reform the educational system and physicians in that respect.

*Kinsella 16:17*

Dr. Paul Henteleff, President of the Canadian Palliative Care Association, informed the Committee that there should be a greater emphasis on providing necessary resources in order to ensure that there will be adequate training in this area:

We need more resources for training so that we do not have to have doctors being taught piecemeal, by nurses who know more than they do. There is room for considerable research because we cannot pretend we already know everything that could possibly be known about how to make people comfortable, despite the fact that they have incurable and fatal illnesses.

*Henteleff 5:9*

A majority of the witnesses felt that providing treatment for the purpose of alleviating suffering should be permitted notwithstanding that it may hasten death and refusing to provide such treatment would be inappropriate and negligent, in some cases. Professor Schafer indicated:

If a physician withholds adequate palliative care on the grounds that it will hasten the death of a patient whose life is more burdensome than beneficial, and who is suffering terribly, and this causes the suffering and the pain to continue, that would now be almost universally recognized as negligent, incompetent, perhaps even criminally negligent medical care.

*Schafer 18:124*



Moreover, Dr. David Roy, Director of the Centre for Bioethics at the Clinical Research Institute of Montreal, stated that a failure to alleviate pain often precludes patients from spending their last moments with family and friends:

There should be no law or morality that would limit a clinical team or doctor from administering the frequent dosages of pain medication that are necessary to free people's minds from pain that shrivels the spirit and leaves no time for speaking when, at times, there are very few hours or days left for such communication.

*Roy 22:7*

### Committee Deliberations

The Committee recognizes that providing treatment aimed at alleviating suffering that may shorten life is legal. However, it also recognizes that there are misconceptions on the part of the medical profession and the public as to the current legal status of this practice. The Committee believes that there should be certainty as to what is and what is not lawful. Treatment aimed at the alleviation of suffering that may shorten life should be considered in the following situations:

- For competent patients, such treatment should be permitted only when the patient has given a free and informed consent.
- In the case of a patient who is incompetent but has completed a valid advance directive while competent, the wishes expressed therein should be respected. In the absence of a valid advance directive, the health care team should turn to the most appropriate surrogate decision-maker. That individual should make a substituted judgment if he or she knows what the patient would have decided were he or she competent. A best interests judgment should be made where the patient's wishes are not known.

The Committee accepts the statements made by many of the witnesses that this type of treatment is currently being provided in Canada. However, it is concerned about the lack of sufficient evidence with respect to the prevalence of this practice. The unavailability of data in this regard is not surprising for two reasons. First, there is conflicting evidence on what sorts of doses actually shorten life. Second, since the legal status of providing treatment aimed at the alleviation of suffering that may shorten life is somewhat unclear to some health care professionals, they are reluctant to admit that they provide such treatment out of fear that they may be held criminally liable.

The Committee is concerned that, as a result of the confusion within the medical profession as to the current state of the law some patients are suffering needlessly because health care professionals are withholding adequate pain medication for fear of liability. In addition, this confusion seems to have resulted in the practice being shrouded in secrecy. This, in turn, may shield the detection of potential abuses in this area. Thus, the

## **Pain Control and Sedation Practices**

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Committee strongly urges that there be a codification in law of the permissibility of this practice and that guidelines be established in order to regulate it.

The Committee is particularly concerned by the evidence that inadequate training of health care professionals in this area may have resulted in some patients suffering unnecessarily. The Committee is of the view that improved education in pain control is essential.

### **Recommendations**

**The Committee recommends the *Criminal Code* be amended to clarify the practice of providing treatment for the purpose of alleviating suffering that may shorten life.**

**The Committee recommends the division of Health Canada responsible for health protection and promotion, in cooperation with the provinces, territories and the national associations of health care professionals, develop guidelines and standards for the provision of treatment for the purpose of alleviating suffering where that may shorten life.**

**The Committee recommends education and training with respect to pain control be expanded and improved for all health care professionals.**

## Total Sedation

The Committee has defined total sedation as *the practice of rendering a person totally unconscious through the administration of drugs without potentially shortening that person's life.*

Dr. Marcel Boisvert, a Professor of Medicine at McGill University and palliative care physician at the Royal Victoria Hospital, illustrates when the technique of totally sedating a patient can occur within the palliative care context:

What we are pushed to do occasionally — not often — in palliative care is that, in some circumstances, in the dying process where distress is so bad that the only way to relieve people is sedation. Shortness of breath is the best example. In the palliative care field it is very often the paradigm of a difficult death - running after and catching each breath, 40, 50 times per minute. We can administer drugs that will relieve this. We can very often relieve 100 per cent of the pain, but rarely can we relieve 100 per cent of severe shortness of breath except by severe sedation.

Boisvert 6:35

On the other hand, Dr. Gordon, provides an illustration of when a patient may be totally sedated in a non-palliative care setting:

The specific cases of barbiturate coma of which I spoke was that which would be induced for the purpose of controlling epileptic seizures...That is a therapeutic use of barbiturates for epilepsy which does not respond to any other treatment. If someone has seizures which will not stop, that is an accepted therapeutic treatment. No one would ever dispute that...It is the use of barbiturates to induce coma in people who are suffering so badly, and whose pain is so uncontrollable, that the only way to control it is literally to put them to sleep.

Gordon 27:19

## Legal Status

The current legal status of this practice is clear. If the sedation is done with the consent of the patient or the patient's surrogate, it is legal. If the sedation is contrary to the clearly expressed wishes of a competent patient or the patient's surrogate, it is illegal — just as any medical treatment without proper consent is, in most cases, illegal. A health care professional who totally sedates a patient against the patient's competently expressed wishes may be charged with assault under section 265 of the *Criminal Code* and may be sued for battery in a civil action in common law jurisdictions. Under the civil law system in Quebec, it should be noted that health care professionals can be held civilly liable for such conduct, pursuant to art. 1457-1481 of the *Quebec Civil Code*.

### **Points of View of Witnesses**

The prevalence of the practice of total sedation is unclear. Although several witnesses alluded to it in the course of their testimony, there was little evidence as to the extent of this practice in Canada. Mr. Réjean Carrier, an experienced social worker who has practised both at Hotel-Dieu de Québec and at the Maison Michel Sarrazin, had this to say:

Some palliative care services have developed after everything else was tried in the way of drugs, special care and attention, the technique of sedation, that is to say putting patients to sleep to render them unaware of their physical or moral pain.

*Carrier 3:8*

Many witnesses who referred to the practice seemed to assume that it was legitimate, as did Dr. Morissette in explaining the circumstances in which the technique may be used:

Artificial sleep...is used in two situations. First, when a person is not yet ready to die but is in such tremendous pain, and second when there is an element of physiological exhaustion, which means that we have a difficult time controlling the suffering with drugs. At that point, the procedure is to induce sleep for a period ranging from several hours to several days and then to allow the patient to emerge from his sleep.

*Morissette 32:19*

Both Dr. Mount and Mr. Don Logan of the Christian Brethren, a religious organization in Winnipeg, also seemed to assume that this practice is permissible:

Sedation of patients where we have been unsuccessful in alleviating suffering is part of palliative care.

*Mount 5:30*

Sedation is a solution for the 5 per cent whose pain cannot be controlled.

*Christian Brethren 18:30*

The argument was put forward by some witnesses that, in their view, this type of total sedation is very similar to acts of euthanasia. Mr. Alister Browne, a biomedical ethicist with the B.C. Civil Liberties Association, held this position:

Some procedures associated with palliative care come very close to active euthanasia, in my opinion. For example, you have heard testimony to the effect that where a patient's distress is difficult to control, they will be "snowed", after having gone through elaborate consent requirements, and put to sleep. They are rendered unconscious, kept unconscious, and perhaps are woken every eight days or so. That measure seems not unlike active voluntary euthanasia.

*Browne 14:136*

Dr. Morissette agreed that these two actions are close; however, he felt that total sedation was the more acceptable approach:



Some places such as Maison Michel Sarazin are already using artificial sleep. Naturally, some ethicists will tell you that we are very close to euthanasia when we resort to this procedure and yes, in effect this is true. However, I believe that this could be a valid option.

*Morissette 32:15*

The concern was raised by many witnesses that, while medical professionals in Canada are providing this type of sedation, there are no existing professional guidelines or national standards governing this practice. Mr. Carrier testified:

There is a danger in using this technique because it could also be abused. For example, who can decide whether a state of distress is unbearable for a patient and whether that patient should be put to sleep. If this technique were an alternative to relieving pain and to euthanasia, an assessment protocol would be necessary in order to prevent it from becoming something that would be easily prescribed.

*Carrier 3:8*

### Committee Deliberations

The Committee recognizes that the practice of total sedation is used in Canada both for the temporary treatment of patients in acute circumstances and for terminal patients. In the case of terminal patients suffering intolerable pain that cannot be relieved by other treatments, the Committee recommends that it be clearly defined when total sedation should be permitted. It therefore recommends that the practice should be considered in the following situations:

- For competent patients, this type of sedation should only be provided when the patient has given a free and informed consent.
- For incompetent patients who have completed a valid advance directive, the expressed wishes should be respected. Where a valid advance directive does not exist, the health care team should turn to the most appropriate surrogate decision-maker. That individual should make a substituted judgment if he or she knows what the patient would have decided were he or she competent. A best interests judgment should be made where the patient's wishes are not known.

The members are concerned that no guidelines whatsoever have been established to regulate this practice in Canada. The Committee is of the view that society has a compelling social responsibility to ensure that the proper regulations are in place to protect against any potential abuses with respect to sedation practices. In this connection, it strongly believes that national standards and guidelines should be developed.

The Committee is of the view that more research and study is required in this area.

**Recommendations**

**The Committee recommends the division of Health Canada responsible for health protection and promotion, in cooperation with the provinces, territories and the national associations of health care professionals, develop guidelines and standards for the practice of the total sedation of patients.**

**The Committee recommends the federal government, in cooperation with the provinces and territories, undertake a study in order to determine the frequency and conditions under which total sedation is practised.**

## Chapter V

# Withholding and Withdrawal of Life-sustaining Treatment

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Medical technology has been evolving at such a pace that life support systems now maintain life for much longer periods. While that technology is a necessary and welcome development, some people view it with reservation. Many people fear a prolonged artificial existence but choose to live under these circumstances, while others believe that a life under these conditions is unacceptable. As a result, medical professionals, patients and others mandated to decide on their behalf are increasingly confronted with decisions concerning withholding or withdrawing life-sustaining treatment. Individuals refusing this type of treatment have successfully sought the approval of our courts, although such decisions have not been codified in statute law. Uncertainty still surrounds the issue.

The Committee has defined withholding life-sustaining treatment as *not starting treatment that has the potential to sustain life* - for example, not instituting cardiopulmonary resuscitation (CPR); not giving a blood transfusion; not starting antibiotics; or not starting artificial hydration and nutrition.

Withdrawing life-sustaining treatment is *stopping treatment that has the potential to sustain life*. Examples include removing a respirator or removing a gastric tube supplying artificial hydration and nutrition.

Withholding and withdrawing life-sustaining treatment can be voluntary, non-voluntary and involuntary:

- **Voluntary** : done in accordance with the wishes of a competent individual or a valid advance directive. For example, a physician removes a respirator at the request of a competent individual.
- **Nonvoluntary** : done without the knowledge of the wishes of a competent or an incompetent individual. For example, when a physician, at the request of the family, removes a gastric tube supplying artificial hydration to an individual in a persistent vegetative state whose prior wishes cannot be determined.

- **Involuntary** : done against the wishes of a competent individual or a valid advance directive. For example, CPR is withheld from a competent individual who has requested that all treatment be provided despite the fact that the health care team has stated that CPR will be futile.

### Legal Status

Mr. Justice Sopinka, writing for the majority of the Supreme Court of Canada in the *Rodriguez case*, summarized the current legal status of the withholding or withdrawal of life-sustaining treatment in the following manner:

Canadian courts have recognized a common law right of patients to refuse consent to medical treatment, or to demand that treatment, once commenced, be withdrawn or discontinued (*Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119). This right has been specifically recognized to exist even if the withdrawal from or refusal of treatment may result in death (*Nancy B. v. Hotel-Dieu de Quebec* (1992), 86 D.L.R. (4th) 385 (Que.S.C.); *Mallette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.).<sup>8</sup>

The *Quebec Civil Code* provides individuals with the right to refuse medical treatment. This right was reaffirmed by the Quebec Superior Court in the *Nancy B* decision.<sup>9</sup> The relevant sections of the *Civil Code* provide:

**Article 10.** *Every person is inviolable and is entitled to the integrity of his person.*

*Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent.*

**Article 11.** *No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent.*

**Article 12.** *If the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place.*

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<sup>8</sup> *R. v. Rodriguez* at p.598.

<sup>9</sup> See *N.B. v. Hotel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Q.C.A.).



Dr. Keyserlingk made reference to the *Nancy B* decision as follows:

The hospital [in *Nancy B*] was concerned, "Are we not killing the patient if we stop the life support?", to which the court replied, "Not at all. This is the patient's right to refuse"...From the hospital's point of view or the physician's point of view, they do not have a right to treat when it has been refused. It becomes a form of assault.

*Keyserlingk 1:32*

It is legally acceptable throughout Canada to withhold or withdraw life-sustaining treatment from competent patients who so wish it. Dr. Keyserlingk and Dr. Ted Boadway, Director of Health Policy at the Ontario Medical Association, said:

Such a duty [to provide life-support] does not exist in some circumstances, one of them being if the treatment is refused by a competent patient...Legally this omission under these circumstances would not be euthanasia by omission, it would simply be good medical care.

*Keyserlingk 1:28*

The current situation ... is that the courts have ruled that physicians must respect and uphold competent patient wishes respecting treatment choices at all stages of life, regardless of whether that may result in a hastened death.

*Boadway 20:70*

The general principle of respect for refusal of life-sustaining treatment for competent patients who request it is widely accepted. There remain a number of difficult aspects of the issue that the courts have not yet settled. There are no decided cases on whether life-sustaining treatment can be withheld or withdrawn from incompetent patients, for example, young children and patients in persistent vegetative states. Futile treatment withheld against the patient's wishes is another grey area in law. A further question that remains is whether artificial hydration and nutrition is a medical treatment that can be withheld or withdrawn in the same way as any other medical treatment. While the courts have dealt with this last issue, they are divided.

In the *Astaforoff* case,<sup>10</sup> the British Columbia Court of Appeal affirmed a decision of the British Columbia Supreme Court in which the judge, while acknowledging the Court's duty to preserve the sanctity of life, went on to hold that that duty did not include requiring the necessities of life to be forced on someone against his or her wishes. By contrast, in the *Niemic* case,<sup>11</sup> the Quebec Superior Court decided the issue in the opposite direction. In that case, the Court authorized a hospital to feed and to treat surgically, in whatever manner necessary, a competent adult who had refused all medical treatment. The Supreme Court of Canada has not yet been asked to rule on these complex issues.

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<sup>10</sup> *Attorney General of B.C. v. Astaforoff* [1983] 6 W.W.R. 322 (B.C.S.C.); aff'd [1984] 4 W.W.R. 385 (B.C.C.A.).

<sup>11</sup> *Procureur Général du Canada v. Hopital Notre Dame et Niemic* (1984), C.S. 426.

## **Withholding and Withdrawal of Life-sustaining Treatment**

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Some witnesses stated that medical professionals require clearer direction with respect to these aspects of withholding and withdrawing treatment.<sup>12</sup>

In reality, however, the common law is not sufficiently clear to be well understood by practitioners or the general public, nor is it completely generalizable from one case to the next, thus leaving enough ambiguity in the minds of practitioners that they are uncertain of their obligations and possible legal liability for either failing to treat or treating. These problems are particularly evident in the case of the patient who is in a persistent vegetative state.

*Boadway 20:70*

The Law Reform Commission dealt specifically with the cessation of treatment:

...There is, rightly or wrongly, some uneasiness among medical specialists and the public in general. This uneasiness lies particularly in the perception that present legislation casts serious doubt on the legality of certain current medical or hospital practices.<sup>13</sup>

Mr. Scott Rowand, President of the Wellesley Hospital in Toronto expressed another concern:

I do not believe adequate legal protection exists, something which was recommended by the Law Reform Commission of Canada in Working Paper 28, for hospitals or professional caregivers in some circumstances in terms of cessation of treatment.

*Rowand 9:32*

### **British Columbia Crown Counsel Policy Guidelines**

The *British Columbia Crown Counsel Policy Guidelines* refer specifically to these activities. These guidelines provide that "withholding or withdrawing treatment means a qualified medical practitioner, with consent by or on behalf of the patient, discontinuing or not intervening with medical procedures to prolong life beyond its natural length. This conduct, when provided or administered according to accepted ethical medical standards, is not subject to criminal prosecution."<sup>14</sup>

These situations are not only problematic from a legal point of view, they also raise moral and ethical questions. The witnesses' views in this respect reflect the difficulties that arise in these cases and the diversity of opinion regarding what is and is not acceptable.

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12 See Appendix G to this Report for an example of an amendment that has been suggested. The Committee does not endorse this specific proposal but rather offer it for illustrative purposes.

13 Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment*, Working Paper 28 (Ottawa: Minister of Supply and Services Canada, 1982) p. 28.

14 The full text of these guidelines is reproduced in Appendix I of this Report.

### Points of View of Witnesses

Some witnesses testified that the arguments for accepting the withholding or withdrawal of life-sustaining treatment from competent persons apply equally to incompetent persons who make requests while competent. Professor Eike-Henner Kluge, who teaches biomedical ethics at the University of Victoria, stated:

If I have shown that competent persons have the right to decide whether they want to live or die, then it follows that same right must also hold for persons who make such requests when they were competent but now are competent no longer.

*Kluge 2:20*

Another point of view expressed by the Lubavitch Organization in British Columbia was that the wishes of an incompetent person cannot ever be known and so no legitimate substituted judgment is ever possible:

Any decision, whether it be to respect a “living will” or the need to make a determination with no known instruction should only be done on the side of the protection of life. Societies over the centuries have used the protection of life as a keystone for their moral foundations. Any move away from this stance will endanger all of society and its values by undermining the fundamental principle of the sanctity of life and our responsibility to protect it.

*Lubavitch-B.C. Brief p.5*

Some of the witnesses described futile treatment as treatment that, based on medical judgment, is completely ineffective. Others described it as treatment that has a low probability of effectiveness and results that are not worthwhile, thus involving both a medical and a moral judgment. Dr. John Williams, Director of the Department of Ethics and Legal Affairs, Canadian Medical Association, testified:

This problem of futility is one of the most difficult ones in medical practice today. The statement that we have presented to you called the “Joint Statement on Resuscitative Interventions”, which was very recently passed by our three associations, addresses the question of futility. It certainly does not answer it, but it at least addresses it, and it sets out some parameters within which the further discussion of futility can take place, in particular, whether it should be a determination by the qualified medical professional that a treatment is incapable of achieving a specified end, or whether it should be a decision on the part of the patient or the family that such an end is either desirable or undesirable.

For instance, is a resuscitation which should perhaps keep a patient alive for another two weeks in the hospital futile or not? The answer may be, “yes and no”. It would not be futile in the sense that it would achieve the goal of keeping someone alive for two more weeks, but whether that goal is worthwhile or acceptable is really a decision that is based on the values of patients, caregivers or whoever. It is an open question, and we have not attempted to resolve it at this time.

*Williams 25:8*

## **Withholding and Withdrawal of Life-sustaining Treatment**

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Some of the witnesses expressed their view that it is acceptable to withhold or withdraw life-sustaining treatment even if the treatment is not futile, for example, a medically necessary blood transfusion for an otherwise healthy Jehovah's Witness. As Dr. Douglas Sawyer, Chair of the Ethics Committee of the Canadian Medical Association, stated:

[In your opinion, should the refusal of treatment be applied only when it is considered futile, or are there other situations?] I think that a patient can refuse treatment for any reason. When a patient refuses, the question of futility does not come up. The question of futility comes up if the patient is incompetent and unable to refuse, but the treatment is considered futile.

*CMA 25:7*

Several witnesses suggested that there is no morally significant difference between the withholding or withdrawal of artificial hydration and nutrition on the one hand and, the withholding or withdrawal of a respirator, blood transfusion, or CPR on the other. Therefore, if one may be withheld or withdrawn, then so too may the other.

Other witnesses held the view that there is a difference between these two types of actions. They said that withholding or withdrawing life support is ethically acceptable, but this does not include artificial hydration and nutrition. Canadian Nurses for Life offered their opinion that withdrawing nutrition and hydration is inappropriate and undesirable:

Providing basic nutrition and hydration has never been medical treatment because neither treat any illness or disease...The following is the text of the resolution passed at the International Congress of the World Federation of Doctors who Respect Human Life which took place in Rome, Dec. 1-2, 1989. This federation has almost 300,000 members in 59 countries. "In every case of terminal illness, it is a cruel and anti-medical practice to withdraw nutrition and hydration and thus to cause the patient to die of hunger and thirst, which can only increase his suffering. Nutrition and hydration are a basic life-maintaining need even if administered intravenously or by gastric tube."

*Canadian Nurses for Life Brief pp.2-3*

Apart from the foregoing problematic areas, many witnesses made general comments about the frequency, and conditions under which withholding and withdrawing treatments that sustain life occur. Some witnesses confirmed that the wishes expressed by patients are in fact being respected in most cases. However, the Committee was also told of some situations in which patients' wishes are not being honoured. For example, Reverend John Oldham, who has had clinical pastoral training at Victoria Hospital in Winnipeg and has led a number of seminars on death and dying, informed the Committee that life-sustaining treatment is sometimes given to patients despite their wishes, or the surrogates' refusal, to consent to it:

Aggressive treatment is sometimes carried out more than necessary, I believe, against the wishes of patients and families, by strong-willed, determined doctors in intensive care units. Sometimes it is overly aggressive. Those are judgment calls and they are very difficult to make.

*Oldham 18: 27*



## **Withholding and Withdrawal of Life-sustaining Treatment**

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Some witnesses related cases in which a health care team withholds treatment, against the wishes of the patient or the surrogate, because it decides that treatment would be futile. The Christian Brethren of Manitoba provided an example:

The Doctor...said that Mother's case had been considered and a decision has been made to withdraw the support machine, and they had in fact, already begun to reduce the number of breaths per minute, and the machine would be switched off completely at 6 p.m.

Father again indicated that he could not give his permission, and he could not interfere with God's own rights in giving life or taking life.

In conclusion I would say, that our state of sorrow and shock at this time was increased by the knowledge that the Hospital Directors had authority to remove the life support machine (by what was conveyed to us), regardless of our feelings about it, and further that we had no power to stop them from doing so.

*Christian Brethren, Brief pp.4-5*

Another issue of concern for some of the witnesses is that there are times when a patient is not in a position to make a free and informed choice as to the refusal of treatment. Here, the role of health care professionals is of utmost importance. Ms. Rodney offered the Committee an illustration of this type of situation based on her experience as a nurse. She recounted a case of a 76-year old diabetic who, as a result of his illness was quite limited in his physical mobility and also required long-term dialysis. As his condition began to deteriorate, he informed the health care team that he wanted to stop dialysis. The team was concerned about this decision because he had not previously mentioned it and the deterioration in his health was not so great as to justify his request:

With some reluctance, he disclosed that he wished to stop his dialysis because he felt he was becoming an increasing burden on his wife and was stressing her own resources. After finding that out, the team...had a much better understanding of how to proceed. They negotiated a new plan of care with him. They arranged to get more homecare support for him to assist him and his wife...Mr. C. and his wife were able to cope much better. He withdrew his request to have the treatment stopped and lived what he described as a good quality of life for another four years.

*Rodney 15:124*

Some of the witnesses shared their views with the Committee on the differences between acts of withdrawing and withholding. A few suggested there is a moral distinction between these. The Lubavitch of British Columbia stated:

The discontinuation of any medical treatment such as respirator, oxygen, intravenous, nasal-gastric feeding or pharmacological treatment cannot be endorsed. It would only be possible to take these actions if the physician knew with absolute certainty that his conduct was not interrupting life. Such a determination is impossible for anyone to make with absolute and total certainty. Therefore, once initiated, instrumental support of vital life processes should not be interrupted unless and until death has been determined.

*Lubavitch-B.C., Brief p.13*

## **Withholding and Withdrawal of Life-sustaining Treatment**

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Dr. Somerville expressed the opinion that there is no ethical distinction between withholding and withdrawing:

There is also an issue about there being any difference between withholding and withdrawing life-sustaining treatment. Ethically and legally there is not, provided in either case the act is justified. Again, to some extent, whether it is justified is a value judgment. However — and I think we need to acknowledge this — withdrawing treatment can feel different from withholding treatment for the health care professionals involved.

*Somerville 6:6*

Despite the different views of the witnesses, they were almost unanimous in finding that withholding and withdrawal of life-sustaining treatment is morally acceptable in principle and that when a competent patient or patient's surrogate refuses to consent to treatment, that decision must be respected. As Dr. Mount remarked:

There is general agreement now that there is no place for the introduction of life-prolonging treatment when the patient is against that or no argument against discontinuing that. That issue has been sorted out and largely agreed to by a broad range of authorities.

*Mount 5:27*

Professor Schafer concurred in this view:

These very powerful values — freedom, liberty, autonomy have led to an almost unanimous consensus in the biomedical ethics and legal communities: that what used to be called 'passive euthanasia' [withholding and withdrawing life-sustaining treatment] is morally legitimate and ought to be legally permissible.

*Schafer 18:122*

## **Committee Deliberations**

The Committee does not believe that there is any moral difference between withholding and withdrawing life-sustaining treatment. Therefore, in its opinion, the same ethical arguments that apply to withholding also apply to withdrawing.

The Committee recognizes that the withholding and withdrawal of life-sustaining treatment is legal when it is requested by a competent patient. However, if the wishes of an incompetent individual are known, through an advance directive or through previous conversations with a family member or a friend, then the surrogate decision-maker should make a substituted judgment and those wishes should be respected. Where the wishes of an incompetent person are not known, then a best interests judgment should be made.

The Committee recognizes that there is uncertainty on the part of the medical profession and the public as to what is legally permissible in this area. The Committee is of the opinion that the practice regarding the withholding and withdrawal of life-sustaining treatment should be clarified in law. In this regard, the following criteria should be considered:

## **Withholding and Withdrawal of Life-sustaining Treatment**

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- When a patient refuses life-sustaining treatment, the health care team should assess the patient's competence.
- If the patient is competent, the health care team should ensure that the patient is making a free and informed choice, in which case the patient's refusal should be respected.
- When the patient is incompetent but has completed a valid advance directive while competent, the wishes expressed therein should be respected. In the absence of a valid advance directive, the health care team should turn to the surrogate decision-maker. That person should make a substituted judgment if he or she knows what the patient would have decided were he or she competent. A best interests judgment should be respected where his or her wishes are not known.
- Life-sustaining treatment should not be withheld or withdrawn against the wishes of a competent individual or his or her surrogate unless the treatment is 'futile', as defined by the Committee.
- Futility must be understood very narrowly as treatment that will, in the opinion of the health care team, be completely ineffective.
- The Committee considers artificial hydration and nutrition as treatment; thus, the withholding and withdrawal of it is as acceptable in some circumstances as is the withholding and withdrawal of artificial respiration, blood transfusions and CPR.

The Committee believes it is unacceptable that life-sustaining treatment is being withheld and withdrawn without adequate guidelines in place governing such practices.

### **Recommendations**

The Committee recommends the *Criminal Code* be amended and necessary legislation be enacted in order to explicitly recognize and to clarify the circumstances in which the withholding and withdrawal of life-sustaining treatment is legally acceptable. The criteria enunciated in this chapter under “Committee Deliberations” should be considered.

The Committee recommends the division of Health Canada responsible for health protection and promotion, in consultation with the provinces and territories and the relevant professional associations, establish guidelines to govern the withholding and withdrawal of life-sustaining treatment.

The Committee recommends professional guidelines be amended so that they are consistent with these recommendations, the amended *Criminal Code*, and the national guidelines.

The Committee recommends the Federal Ministry of Health, in cooperation with the provinces and territories, sponsor a national campaign designed to inform the public as to their rights with respect to the refusal of life-sustaining treatment.

The Committee recommends research be conducted in order to determine the frequency with which and conditions under which life-sustaining treatment is withheld or withdrawn under the recommended legislation and guidelines.



## Chapter VI

### Advance Directives

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Throughout the Committee hearings, witnesses referred to the importance of patient involvement in health care decisions and the emergence of advance directives as a method of accomplishing this. Health care professionals emphasized that it is crucial that patients guide medical practitioners and nurses as to what treatments they do and do not want. This is also important for family members who are often faced with making critical decisions for one another regarding matters of health. These decisions are much easier when families are aware of the wishes of the patient.

An advance directive, referred to as mandate in the *Quebec Civil Code*, and also commonly known as a living will, is a document executed by a competent individual concerning health care decisions to be made in the event that the individual becomes incompetent to make such decisions. Advance directives can be divided into two categories: instruction directives, and proxy directives also known as durable powers of attorney for health care. In an **instruction directive**, an individual sets out *what or how health care decisions are to be made* in the event that he or she becomes incompetent. In a **proxy directive**, an individual sets out *who is to make health care decisions* in the event that he or she becomes incompetent.

#### Legal Status

Most provincial legislatures in Canada have enacted or are considering some form of legislation regarding advance directives. Quebec, Ontario, Manitoba, and Nova Scotia have passed and proclaimed legislation that codifies respect for advance directives into law. In British Columbia, legislation has been passed but not yet proclaimed. Newfoundland's *An Act Respecting Advance Health Care Directives and the Appointment of Substitute Health Care Decision Makers* was reintroduced on March 16, 1995 and is currently awaiting committee study.

While no legislation exists on advance directives in some provinces, a few are studying the issue or considering legislation in this regard. Alberta had introduced legislation, the *Advance Directives Act*, however, it was dropped from the *Order Paper* when the legislative session ended in November 1994. The Minister of Health is currently accepting and analyzing public input received as a result of a discussion paper concerning advance directives before any new plans are made to reintroduce legislation.

## Advance Directives

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In the Northwest Territories, the development of guidelines entitled *Standards and Procedures for Advanced Treatment Directives for both Coordinated Home Care Programs and Facility based Long Term Care Programs*, has been initiated by the Department of Health. In New Brunswick, a committee established to study advance health care directives has presented its report to the Department of Justice. The Department intends to study the report to determine whether legislation is required.

Prince Edward Island, Saskatchewan, and the Yukon have no current plans to introduce legislation or to study the issue.<sup>15</sup>

### Points of View of Witnesses

Most witnesses agreed that advance directives should be legally binding in all provinces and medical staff should be required to defer to patients' wishes, expressed through valid advance directives. Dr. Latimer, for example, supported this view:

I would be in favour of people having the option to decide about their treatment which can be conveyed in a living will, in terms of what sort of treatment they would like to have toward the end of life. In other words, they may choose not to have certain kinds of therapies which prolong their life. They should have the right, or the option to be able to choose.

*Latimer 4:10*

Dr. Latimer also noted how such legislation could serve the health care profession:

Anything that can clarify for doctors and health care systems the sort of treatment a person wants to have is to be applauded. If it happens through a living will or through the durable power of attorney, coming into effect soon [in Ontario], or a combination of the two is to be applauded. A patient simply letting their doctor know the general nature of their wishes about those kinds of things can only be applauded.

*Latimer 4:10*

Mr. Carrier and Ms. Chapman explained some of the benefits of mandating observance for advance directives:

In my view, the living will is an interesting option to the extent that we can ensure that no treatment will be given against the person's will and that it will be possible to check with the person to see what he or she wants at the end, if, of course, that person is still able to choose...The [living] will can protect against "aggressive therapy".

*Carrier 3:13*

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<sup>15</sup> See Appendices J and K to the Report for a more detailed summary of the status of advance directives legislation in Canadian provinces.

The legitimacy of the advance directive as enshrined in the provincial legislation will address some of the problems regarding treatment decisions, such as the withholding of treatment if a person's wishes are known prior to his or her becoming ill. In accordance with the advance directive, treatment or non-treatment will respect the individual's wishes and ensure that these wishes are respected in the event that the person is not able to express his or her own views. Many of the difficult situations and eventualities that arise at the end of life could be prevented if this legislation were available across the country and advance directives became widespread.

*Chapman 32:57*

Mr. Bureau pointed out that expressing free and informed consent or refusal of treatment by way of advance directives aids the family and friends when faced with the task of making difficult decisions:

If the dying person's wishes are honoured, the mourning process will be facilitated, less painful and certainly less destructive because there will be less guilt and tension in the family and among the caregivers.

*Bureau 4:36*

A few witnesses, however, expressed some reservations. Dr. Keyserlingk testified:

The problem with this whole movement is, if we all start writing our wills and saying that we do not want certain things at the time when it becomes heroic, it could be that the burden will shift. Then, if people do not have a living will, medicine will begin to think, "I guess they want everything".

*Keyserlingk 1:52-53*

Professor Mishara pointed out that a living will makes it more difficult for people to change their mind about their wishes:

So one of the problems...is how to protect the rights of individuals to change their mind; they may have signed a piece of paper one day when they were feeling alone and isolated...but after the pain is effectively relieved, they feel better and they feel differently.

*Mishara 2:41*

Some nurses expressed a number of concerns:

This emphasis on the need for a living will also implies that, unless clearly directed by their patients, nurses will give poor nursing care; the patient has lost any or all right to refuse treatment and that these rights must be acquired by signing a legal document; that patients must expect to be treated excessively if no such document exists; that patients unable to exert their rights have no rights. Canadian Nurses For Life believes that there does not appear to be any good reason for making into law what is already good nursing practice...The underlying premise of requiring a living will is that nurses not only treat patients contrary to their wishes, but that they routinely overtreat patients.

*Nurses for Life 8:7*

## **Advance Directives**

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Ms. June Scandiffo, of the Right to Life Association of Toronto, stated the following:

Certainly, the idea of having one person that you trust speak for you is valid. The thing that must be remembered is that people have to be aware of things like conflict of interest. Obviously, the person who signs such a document must trust you and your judgment. But not all of us are trustworthy. Will there be coercion in signing these things?

*Scandiffo 8:52*

## **Committee Deliberations**

While the Committee is aware of the concerns raised by some of the witnesses with regard to legally mandating respect for advance directives, the benefits appear to be significant. The members hope that those provinces and territories that have not already done so will implement advance directives legislation in the future.

The Committee is concerned about the apparent complexity of some existing legislation on advance directives. The members are of the view that if the process of preparing and executing such documents is clear, straightforward and available at minimal cost, more people will be encouraged to complete advance directives.

## **Recommendations**

**The Committee recommends those provinces and territories that do not have advance directive legislation adopt such legislation.**

**The Committee recommends the provinces and territories establish a protocol to recognize advance directives executed in other provinces and territories.**



## Chapter VII

### Assisted Suicide

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**A**ssisted suicide is defined as *the act of killing oneself intentionally with the assistance of another who provides the means, the knowledge, or both.*

Examples of assisted suicide include the following:

- a physician gives a patient information about how to take a lethal dose of a drug and writes a prescription for the drug knowing that it is the intention of the patient to kill himself with the drug. The patient takes the lethal dose and dies as a result.
- a friend of a partially-paralysed woman goes to the pharmacy to get a prescription for barbiturates filled, brings them to her, pours them into her hand, and brings her a drink to wash down the pills. The woman takes the pills with the drink and dies as a result.

The necessary and sufficient elements of assisted suicide are that the patient is the agent of death but death results from the assistance supplied by another person.

Refusal of treatment is not suicide or assisted suicide, nor is treatment aimed at the alleviation of suffering that may shorten life. Euthanasia is also not a form of assisted suicide because, unlike assisted suicide, the final act is not accomplished by the person wishing to die.

#### Legal Status

Neither suicide nor attempted suicide are illegal in Canada, the offence of attempted suicide having been repealed in 1972. Assisting with a suicide, however, is a criminal offence. Section 241 of the *Criminal Code* provides that:

**241. Every one who**

(a) counsels a person to commit suicide, or

(b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

Assisted suicide is an offence under subsection 241(b). “Aids and abets” under this provision includes providing the information or the means to a person who commits suicide. This sub-section is the focus of the present chapter.

### The Common Law and the *Charter*

The leading case in this area involves Sue Rodriguez who, at the time of the Supreme Court hearing, was a 42-year-old woman suffering from amyotrophic lateral sclerosis (ALS, also known as “Lou Gehrig’s Disease”). The prognosis for her type of ALS was a steady loss of physical ability, for example, walking, speaking, swallowing, and breathing, followed by death in two to fourteen months. Near the end, she would be conscious and aware of her situation but bedridden and completely dependent upon the care of others and the support of artificial respiration, hydration and nutrition.

Sue Rodriguez did not want to die as long as she had the capacity to enjoy life, but realized that there would come a point where she would no longer be able to commit suicide without assistance. She commenced a court action, asking that the *Criminal Code* provision prohibiting assisted suicide be declared contrary to the *Charter*. As the Supreme Court of Canada phrased it, she asked “that a qualified physician be allowed to set up technological means by which she might, when she is no longer able to enjoy life, by her own hand, at the time of her choosing, end her life.” She was unsuccessful in the courts and died in February 1994. It is uncertain whether her death involved assisted suicide or voluntary euthanasia. No charges have been laid.

In a five to four decision, the Supreme Court of Canada held that the provision against assisted suicide, section 241(b), does not offend the *Canadian Charter of Rights and Freedoms*. While the prohibition against assisted suicide infringed Sue Rodriguez’s *Charter* right to liberty and security of the person, it did not do so in a manner contrary to the principles of fundamental justice. It was also argued on her behalf that a handicapped person wishing to commit suicide, but physically unable to do so, had a right to assisted suicide under the equality provisions. Mr. Justice Sopinka who wrote for the majority held that, even if there had been a breach of the *Charter*’s equality provisions, this would be demonstrably justified in a free and democratic society pursuant to section 1 of the *Charter*.

There were three dissenting opinions. Chief Justice Lamer held that the prohibition against assisted suicide limits the right to equality guaranteed under the *Charter* and that the limitation is not demonstrably justified in a free and democratic society. He concluded that the vulnerable could be protected in a manner that does not limit the equality rights of the disabled. Madam Justice McLachlin (with Madame Justice L’Heureux-Dubé

concurring) held that the prohibition against assisted suicide infringes the right not to be deprived of life, liberty, and security of the person except in accordance with the principles of fundamental justice and is not demonstrably justified in a free and democratic society. She held that the vulnerable could be protected in a manner that does not limit the right to liberty of Canadians in an arbitrary manner. She found the equality provisions of the *Charter* to have no application in this case. Mr. Justice Cory agreed substantially with both Chief Justice Lamer and Madam Justice McLachlin; he held that the prohibition against assisted suicide infringed both the right not to be deprived of life, liberty, and security of the person except in accordance with the principles of fundamental justice and the right to equality and also that the infringement is not demonstrably justified in a free and democratic society.

It is important to note that five judges upheld the present law on assisted suicide, while four rejected it. A more detailed summary of this decision is reproduced in Appendix N to this Report.

### **British Columbia Crown Counsel Policy Guidelines**

The British Columbia Attorney General has issued *Crown Counsel Policy Guidelines on Active Euthanasia and Assisted Suicide*.<sup>16</sup> The Committee is unaware of any other provinces that have issued similar guidelines. According to the British Columbia guidelines, a medical practitioner will not be subject to criminal prosecution for assisted suicide and euthanasia unless there is a substantial likelihood of conviction and the public interest requires it. They provide that:

A substantial likelihood of conviction is significantly more a *prima facie* case, but considerably less than a virtual certainty of conviction...For this reason, Crown Counsel must be flexible in applying the substantial likelihood of conviction standard recognizing that the more serious the allegation, the greater the interests of justice in ensuring that provable charges are prosecuted.

The specific factors to be considered in determining whether the public interest requires a prosecution include:

- The importance of supporting proper professional and ethical standards within the health care professions;
- Society's interest in the protection of vulnerable persons; and
- Society's interest in protecting the sanctity of human life, recognizing this does not require life to be preserved at all cost.

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These guidelines have been reproduced in full in Appendix I to this Report.

### **Points of View of Witnesses**

The Committee heard a wide range of ethical, social and legal arguments ranging from requests for the outright legalization of assisted suicide to suggestions that society should take stronger measures to clarify the fact that suicide should always be discouraged.

Despite the clear illegality of assisted suicide, the Committee heard testimony that assisted suicide does take place in Canada. Other witnesses, however, have said that assisted suicide is very rare. Most witnesses who testified did not make a clear distinction between assisted suicide and euthanasia making it difficult to establish any dependable figures. Russel Ogden, whose M.A. Thesis was on assisted suicide and euthanasia of persons who have AIDS or HIV, and Dr. Boadway both stated that assisted suicide takes place on a regular basis:

I discovered that here in British Columbia, euthanasia in the AIDS population occurs both with and without the assistance of physicians. Between 1980 and 1993, I learned of 34 cases of assisted suicide or euthanasia amongst the AIDS population. I also learned of other deaths outside of the AIDS population, but I did not include those in my data. I have learned of many more deaths amongst patients with ALS, cancer and AIDS since the publication of these findings.

*Ogden 14:75-6*

Since I spoke out about assisted suicide a year ago, I cannot stop people talking to me about it [including] physicians and nurses. I deliberately try to avoid learning anything about the circumstances of the case because I do not want to know. However, I can tell you that it is constant.

*Boadway 20:83*

On the other hand, Reverend Kenneth Weir, a chaplain from New Brunswick, stated:

I can honestly sit before you and say that I have been there, I have worked with the staff, I have lived in the profession for nine full years, it has been my life, and I know what goes on in the institutions. I cannot cite one single instance of this [assisted suicide] happening in our institutions. . . Such happenings do not go unnoticed or unspoken about, and I have the confidences of doctors and nurses, and the ancillary staff.

*Weir 24:22*

Because of the reluctance of witnesses to discuss illegal activities, it was not possible for the Committee to gather accurate or complete information on the incidence of assisted suicide. As Reverend Oldham said:

There is no question in my mind and in my heart that there are many people across this nation, professional people and others, who are not here because of the fear of investigation and potential punitive action.

*Oldham 18:28*



Dr. Chochinov pointed out to the Committee that there is very little information overall about who requests assisted suicide, or why they do so:

What do we know of this group for whom physician-assisted death would be considered? The answer is: exceedingly little. How large a group might this be? What is the distribution of their underlying disease processes and burden of symptoms? To what extent does pain, depression and social support influence the desire for death? To what extent can intervention influence or alter one's desire for death? These are all empirical research questions which can and must be answered.

*Chochinov 17:6*

The Committee was unable to ascertain how often assistance is requested and by which patient groups, how often assisted suicides are taking place, and under what conditions assistance is being requested and provided. The Committee heard sufficient evidence to suspect it is being requested and provided.

### **Witnesses Arguments Against Decriminalizing Assisted Suicide**

One of the most commonly heard arguments against assisted suicide was the importance of protecting life as a fundamental societal value. A related argument involved the sanctity of life, but the two are not the same. Life is a fundamental societal value because society cannot survive if this value is not protected. The Thomas Moore Lawyers' Guild and Dr. McGregor described the fundamental value of life as follows:

Recognition of this social context in which individual rights are considered is crucial, we believe, especially when dealing with the issue of life and its protection. Societies are judged by their treatment and protection of life.

*Thomas Moore Lawyers' Guild*

Euthanasia and assisted suicide are contrary to the basic respect for human life which is at the core of societal values.

*McGregor 4:55*

Those who base their opposition to assisted suicide on the value of the sanctity of life use different terminology. They consider all human life sacred as reflected in such religious principles as "Thou shalt not kill". This value was emphasized in terms of the Judeo-Christian tradition. Dr. Senn and Reverend J.A. Baycroft of the Anglican Church of Ottawa said:

The Judeo-Christian belief still plays a major part in our society. It says that life is not something that we arrange for ourselves, that it is a gift and that we have no more right to take it away ourselves than we did to demand it to start with.

*Senn 9:6*

## Assisted Suicide

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I believe that my life is part of the whole of human life, that it is not simply my individual possession. Not only am I required to respect the lives of other people, but my respect for my life is indivisible from my respect for the lives of others. If I set an example by abandoning my will to live, should I be depressed enough and should things get tough enough, there is a danger that that will weaken the thresholds and undermine the commitment of others, particularly the vulnerable in society.

*Baycroft 28:8*

The notion of respect for life was also expressed by representatives of the Alberta Indian Health Care Commission:

The elders and spiritual leaders firmly respect life. In their prayers, they pray for people to have a long and respectful life. It is not part of our culture to actually approve of someone taking their own life. They do not want to alter nature. When it comes to terminally ill people, they leave it in the hands of the Creator. They will make every effort to ensure that an individual does get well. They will pray for that person right to the final breath.

*Bottle 30:23*

In addition, some witnesses pointed out that, while personal autonomy is a value in our society, it is not absolute:

† The principle of self-determination, of the patient's autonomy, goes hand-in-hand with interdependence. We can't have one without the other. We are individuals living in a society, a community and the community has rights when it comes to an individual member's behaviour. Our whole society is based on this, and one person's actions can set off emotions or consequences for his family and his immediate neighbours in the community.

*Dionne 13:12*

Many witnesses referred to the concept of a "slippery slope". They fear that allowing assisted suicide would inevitably lead towards allowing voluntary euthanasia, and perhaps even the involuntary euthanasia of the elderly, the disabled, and other vulnerable individuals. Although it may be presented in simple terms, the issue is more complex and involves concerns about emotional, psychological and financial pressures that may make it difficult to restrict assisted suicide if it is allowed at all. Doctors Roy, Adams and Johnston characterized it as follows:

It is illusory, or at least highly questionable, that a society would be able to uphold the voluntary character of euthanasia once it became legally, socially and ethically acceptable for many people. It would be difficult, if not impossible, to construct a law that would prohibit people from using persuasion, however subtle, on people to request euthanasia when that is probably not what they want.

I have seen that, particularly with respect to AIDS patients who have been totally abandoned by their parents, brothers and sisters and by their lovers. In a state of total isolation, cut off from every source of life and affection, they would see death as the only liberation open to them. In those circumstances,

subtle pressure could bring people to request immediate, rapid, painless death, when what they want is close and powerful support and love.

The assumption that we could maintain the voluntary character of euthanasia is linked to a naive idea that we live in an ideal world of ideal hospitals, doctors, nurses and families, but I have been around too many bedsides and I have seen too many circumstances of intense strife where lucidity is absent and chaos dominates for a period of time.

*Roy 22:8*

There could be a negative impact upon the present regard accorded to the elderly, the physically handicapped, the mentally ill, the infirm, and the seriously impaired newborn.

*Adams 18:45*

However, knowing my own weaknesses and recognizing the weaknesses I have seen around me in the practice of medicine, within hospitals, and within the health care system in Canada, I can simply say to those who would ask so eloquently for these freedoms that, on the ground, in the trenches where it matters, the first to die would be the weak and inarticulate, the defenceless, not the strong-willed, those possessed of unattractive situations or stories of particular hardship. It would be the ordinary people whose continued existence is resented by unsympathetic relatives or an unsympathetic health care system.

*Johnston 14:28*

Witnesses who opposed decriminalization of assisted suicide saw an essential difference between withholding and withdrawing, and assisted suicide. They argued that when life-sustaining treatment is withheld or withdrawn, death results from natural causes. When assistance with suicide is provided, death results from unnatural causes. As Dr. Morissette pointed out:

When you cease treatment or disconnect a person from life-prolonging equipment because the treatment has become disproportionate or because the individual feels he no longer has the desire or the ability to fight, there is a clear difference between allowing death to occur naturally and causing it. I believe that, essentially, the crux of the answer lies in this. It is the whole question of allowing death to occur naturally versus causing it.

*Morissette 32:14*

Many witnesses referred to the difference in intention between the activities discussed earlier in this Report, such as withholding and withdrawal of life-sustaining treatment and treatment aimed at relieving suffering that may hasten death, on the one hand and assisted suicide on the other. Dr. Latimer illustrated this idea:

Some proponents would also say that palliative care is just one step short of euthanasia and that there is really not a great deal of difference between the two. They might also say that some of the drugs we use for effective pain control may result in the end of life of a patient and that, therefore, this is equal to euthanasia. These are also false. Using appropriate therapies for the treatment of severe pain, shortness of breath and other symptoms, has as its goal the relief of suffering, not the death of the patient. The goal of euthanasia and assisted suicide is the death of the patient and any interventions that are taken are designed to achieve that. The field of palliative care and hospice care must not be seconded or distorted by pro-euthanasia groups who may wish to champion their own issues. There is a clear distinction between effective palliative and hospice care and any practice of euthanasia and physician-assisted suicide.

*Latimer 4:7*

A number of witnesses argued that it would be premature to permit assisted suicide until good palliative care is available to all Canadians. Only then will it be possible to accurately assess the potential benefits and potential harms of permitting assisted suicide. Dr. Richard MacLachlan, of the College of Family Physician of Canada, made this point succinctly:

We believe that it is absolutely imperative that only with a comprehensive palliative care and suicide prevention program available throughout the country should there be a consideration of assisted suicide or euthanasia.

*MacLachlan 23:6*

It was also argued that good palliative care would make it possible to alleviate the suffering which leads to requests for assisted suicide, without the harm associated with assisted suicide.

I believe that we have not exploited all possibilities in palliative care. Let's exploit all the possibilities and then perhaps we'll say "Yes" or "No" to euthanasia; we will know.

*Carrier 3:21*

Unfortunately, that form of treatment [palliative care] is not available to all Canadians. One of the serious issues that this raises is: Can we, as a society, condone some form of active euthanasia if we cannot first guarantee that all Canadians have access to quality palliative care to diminish their physical and psychological suffering?

*Mishara 2:36*

Additionally, some witnesses felt that palliative care might result in reducing the requests for assisted suicide to a sufficiently low level that the harms of permitting assisted suicide would clearly outweigh the benefits. Dr. Kinsella, among others, made this point:



There will be cases that we will not be able to handle properly. Those cases will be hard cases, and I do not know what else to say other than the fact that they will be hard cases. I do not mean to be debonair and cavalier and dismiss the horrors and suffering that these people will endure, but it is a reality. We will not be able to help some of them to the extent that we would like to help. That does not mean that the rare cases should drive the social and moral fibre of this country in terms of its attitudes towards dying, and this is a step that I, personally, simply cannot bridge. We cannot say that we have to change the ethics of this country for the occasional dreadful, horrible case that cannot be accommodated by the system.

*Kinsella 16:20-21*

Another argument concerning palliative care was that allowing assisted suicide would reduce the incentive to further develop palliative care in Canada. A number of palliative care specialists appearing before the Committee expressed this view:

[If euthanasia or assisted suicide is legalized] research into pain control and special psychosocial and spiritual care and attention for patients could well decrease and indeed even become no longer a priority. The same would be true of palliative care programs.

*Carrier 3:10*

One of the fears I would have if we were to introduce euthanasia/assisted suicide changes in law is that we would lose the momentum we are achieving for the care of the dying.

*Latimer 4:9*

A major concern of witnesses opposed to changes in the law on assisted suicide was the potential pressure that would be placed on vulnerable and sick people. Patients may see themselves as being a burden on their family or friends or on society in general, or they may be vulnerable to other external pressures, and consequently request assisted suicide even though they do not really wish to die. The Canadian Conference of Catholic Bishops, the Council on Aging (Ottawa-Carleton) and Pauline Lesage-Jarjoura of the University of Sherbrooke Ethics Committee, all commented on this issue:

The frail, poor, elderly and others who are vulnerable will be subject to pressure from third parties or even themselves if an earlier death is an option. This pressure could increase as health care resources decrease. At what point does the possibility of choosing death become an obligation?

*Canadian Conference of Catholic Bishops 22:49*

We are concerned about the pressures, both internal and external, on individuals and on their caregivers to unnaturally lengthen or shorten the process of dying. The evolution of medical technology to maintain life and its availability for use in the care of the individual has created a new context within which the dying process must be assessed. All of these pressures influence our decisions with respect to euthanasia and assisted suicide.

Internal pressures affecting the individual may include the fear of death, however, for many seniors it is not so much the fear of death itself as the fear of a painful death which causes stress. Loss of control, concern over being able

to financially pay for the support required to continue living, and the fear of becoming a burden to family members are further internal pressures that can affect an individual's desire for euthanasia and assisted suicide. In certain situations, individuals may make decisions which are not in their best interests but rather with the intention of protecting and safeguarding their families from the emotional and financial pressures that may ensue. ... A major concern raised by members of the council was the increased vulnerability of seniors. With age, physical abilities and sometimes mental abilities decline, often leaving the individual dependent on others and thus vulnerable to victimization. Financial abuse is quite common, with seniors losing part or all of their savings or being pressured to turn over their monthly income to the management of another person. In some extreme cases, seniors live with the knowledge that there are those who wish them dead so as to profit from their estate.

*Council on Aging 32:54*

In a world that does not try to give a positive meaning to old age and suffering, it will become "normal" to ask to put an end to life and "abnormal" to want to live despite subtle pressure from all sides. We will have to justify our own survival.

*Lesage-Jarjoura Brief, p. 19*

Some witnesses felt that coming to terms with suffering and the suffering associated with dying were an important part of life, and neither could nor should be avoided by such mechanisms as assisted suicide and euthanasia. Suffering can bring the individual and the community together, and unite them both with higher values. Dr. Morissette commented:

It is necessary, and I firmly believe this, to have suffered oneself in order to understand the suffering of others, whether it involves grief, deep or transitory, the loss of a loved one, a wrenching experience, or rejection and heartache in love. Sometimes, when we have learned lessons from our own sufferings, when we have been able to do this, we come to think that those who have not suffered have perhaps not truly lived. The experience of meaningful suffering can have a spiritual dimension. I do not wish to glorify suffering here because it must be relieved, but it is part of the human condition.

*Morissette 32:10-11*

Several witnesses referred to the possibility of personal and family reconciliation and growth in the last few months or days of life, which would be lost had the individual chosen the option of assisted suicide. Both Reverend John Horgan, of the Catholic Health Association of British Columbia, and Iain Benson, of Canadian Physicians for Life, described this process:

During the last six months of life, we find that our patients often reassess and realign hope. Hope is often restructured. It is no longer hope for cure, but there is hope that one might see and enjoy loved ones. There is the possibility of resolution, reconciliation and the experience of forgiveness in the circle of loved acquaintances. There is the opportunity for new manifestations of care, compassion, and affection for the dying. This is what the dying person receives from the caregivers and loved ones. The caregivers — and I speak as a professional — receive immensely from our patients and our families.

*Horgan 14:149*

A month ago I sat at the bedside of a very dear friend of mine who was 39 years old and dying of cancer. Two months before she died, she asked her husband to help her commit suicide. He refused. Three days before she died she had what can only be described as an extraordinary reconciliation with her family. This would not have happened had the suicide request been granted.

*Benson 14:24*

Witnesses suggested that assisted suicide could have a very negative effect on family members, friends or health care professionals involved with the person who dies. It was recommended that the implications for other persons associated with an individual requesting assisted suicide be further researched. As the Canadian Pharmaceutical Association put it:

Pharmacists are divided on the issue of euthanasia and assisted suicide. We cannot make a strong recommendation on the legalization of those procedures. The debate on physician-assisted suicide in Canada and the United States continues to focus almost exclusively on the rights and responsibilities of the two principles, the patient and physician. This raises an important and largely overlooked question. What are the rights and responsibilities of, for example, the health care professionals that might be involved in physician-assisted suicide or euthanasia. Is physician-assisted suicide or euthanasia an appropriate use of prescription drugs? Is it appropriate for a physician to involve a pharmacist in assisted suicide or euthanasia without the knowledge of the pharmacist or their consent? Should and would pharmacists knowingly participate in ending a patient's life? If so, under what conditions? From an ethical perspective, should euthanasia be legalized?

*Hall 23:22*

Mr. Carrier also stated:

Having worked with people, family members who have had to mourn a parent who has committed suicide, it appears that the suicide of a parent is a very difficult moral and spiritual legacy for a son or daughter to accept. What will be the case with euthanasia or assisted suicide? What will be the impact? How will relatives experience mourning?

*Carrier 3:11*

Mr. Mark Pickup testified:

Canada is not made up of 27-million little islands! If I choose to end my life via doctor assisted suicide, it does not just affect me. It will affect my wife, my children, my mother and siblings. It will diminish my doctor's view of her own profession (because she will have traded her role as healer for the role of executioner) and, in a general sense, it will threaten the doctor-patient trust relationship...We are interdependent. Words like "family" "neighbours" "community" and "citizenship" attest to this reality. Individualistic autonomy is a myth.

*Pickup, Brief p. 16*

The concern was expressed that decriminalizing assisted suicide would erode the trust that exists between patients and their physicians, nurses and other health care professionals. This was linked to a concern that assisted suicide would violate a fundamental ethic of medical care, calling into question the motives of caregivers.

An important basis of trust in the doctor-patient relationship is that patients trust their physicians to do no harm. It may be that euthanasia and assisted suicide may well undermine this trust, interfering with the doctor-patient relationship and with open and honest communication with the patient and the physician.

*McGregor 4:55*

Historically, medicine has prohibited euthanasia and physician-assisted suicide as medical acts. This prohibition derives from medicine's Hippocratic imperative to do no harm...Clearly and undeniably, legally tolerated active euthanasia and assisted suicide would render the teaching and learning of medicine an undertaking of incompatible and macabre duties. Medicine as we have known it would die in such an environment. When medicine as we have known it dies, so too will the ethic of Hippocrates which has ensured for centuries that health care should do no harm.

*Kinsella 16:7,11*

Several physicians also warned that economic restraints on the health care structure might lead to assisted suicide occurring more often than anticipated, were it to be legalized. Both Dr. Jim Lane, of Canadian Physicians for Life, and Dr. Roy expressed this concern:

The most expensive time in a patients life is the last months. Many think that the patients would not be killed to save money but the prospect is there.

*Lane 14:26*

In an era where it is difficult to provide adequate care for people due to budgetary constraints, we have some AIDS patients who cannot receive drugs for serious infections. Within these constraints, a law that would permit euthanasia and give it social blessing could end up being something that was altogether too socially convenient.

*Roy 22:11*



Some witnesses were of the view that, if assisted suicide were legalized, it would not be possible to establish adequate guidelines to safeguard against abuses no matter how carefully they are drafted. It would be difficult to ensure that such guidelines were followed in any given circumstance:

As lawyers, we can safely say that our collective experience shows that any system of legal guidelines, no matter how well-intentioned, will inevitably result in errors, given the simple fact that guidelines are administered by human beings and all humans err and fail.

*Thomas More Lawyers' Guild 12:9*

I believe that every safeguard that could be created has weaknesses and is open to failure. We know that what doctors do and say to patients is done behind closed doors and is between the doctor and the patient. In the case of euthanasia, the only witness that could testify that safeguards were or were not followed would be dead. The other witness to the safeguards would be unlikely to testify against him or herself. Legislative safeguards of physician-assisted suicide protect the doctor against prosecution, not the patient or the public. I believe that it is my duty as a physician, and a duty of my profession, to tell the public how difficult it would be to monitor and police any safeguards.

*Lane 14:26*

Another concern raised was the difficulty of preventing some instances of nonvoluntary euthanasia, or even murder, from being disguised as assisted suicide.

Since motives are so important in assisted suicide, as they are in euthanasia, is it possible to be assured that the motive was mercy as opposed to something else?

*Keyserlingk 1:44*

Finally, there was a fear that any move to decriminalize assisted suicide would send the wrong message to those groups most vulnerable to suicide in our society. Mr. Gary McPherson, the Chairman of the Alberta Premier's Council on the Status of Persons with Disabilities, said:

Canada has identified a suicide problem among its youth, and we have responded "How can we prevent it?". Canada has identified a suicide problem among Aboriginal peoples and we have responded "How can we prevent it?". Canada has identified a suicide problem among people with disabilities and we have responded "How can we assist them to kill themselves?".

*McPherson 18:53*

### Witnesses Arguments In Favour of Decriminalizing Assisted Suicide

Witnesses in favour of decriminalization made the argument of respect for the principle of autonomy or the capacity for self-determination. Dr. Boisvert said:

Is life a transcendental value? Is it a value that literally transcends everything? The simple, clear-cut answer to that is "No". We do not transfuse Jehovah's Witnesses; we allow people to refuse treatment that will bring about their death in a short while. In Canada, and in most western countries now, life is not a transcendental value. We recognize that to be alive is just not enough. There has to be more to it. The autonomy of persons, or of patients, can be greater than life.

*Boisvert 6:29*

Dr. Wallace, in referring to the principle of autonomy, cited the 1983 report of the Law Reform Commission of Canada which provides:

Law must also recognize, as it now does implicitly, the principle of personal autonomy and self-determination, the right of every human being to have his wishes respected in decisions involving his own body. It is essential to recognize that every human being is, in principle, master of his own destiny. He may, of course, for moral or religious reasons, impose restrictions or limits on his own right of self-determination. However, these limits must not be imposed on him by the law except in cases where the exercise of this right is likely to affect public order or the rights of others.<sup>17</sup>

Dr. Wallace went on to say:

Unfortunately, the Law Reform Commission chickened out when it came to make recommendations, because, on this particular issue, they decided that since prosecutions are rarely laid, and since the person usually gets a suspended sentence, they see no reason to change the law. If that is not putting the cart before the horse, I do not know what it is. I would suggest rather that if we have a law which is rarely used, and when it is used it is a tap-on-the-wrist penalty, then we do not need that law.

*Wallace 15:84*

Some witnesses felt that the pain and suffering of dying patients that cannot be alleviated justifies permitting assisted suicide. Mr. Tom Sigurdson from Alberta testified in this regard based on his own experience:

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17 Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment*, Working Paper 28, p.37

There was physical pain every morning with the routine morning wash, and the same in the evening. There was incredible physical pain and horrible indignity every time her bowel had to be cleared manually...No one should have to suffer the pain and indignity which my wife suffered. Her body betrayed her, and she should have been allowed to die at a time of her choosing. ... I appear before this committee to ask, indeed to beg, that your final recommendation to Parliament be one that allows the terminally ill a choice — a choice to leave this world when they are satisfied that there is no quality of life left for them, or when their pain and suffering is too great. Had Cynthia been given that choice, there could have been a time when I would have kissed her goodbye and held her until she exhausted her last breath. Instead, I am left with a memory of horrible pain and a hollow haunting stare. I pray that soon no Canadian will have to suffer such pain and indignity against their will.

*Sigurdson 15:122-123*

Some witnesses told the Committee that a prolonged dying process can cause a loss of dignity. Furthermore, it can lead to a loss of independence and control over their lives which for them, is paramount. Professor Kluge and Ms. Marilynne Seguin, of *Dying With Dignity*, both made this point:

Ms Rodriguez had made it very clear, both publicly and privately, that the manner of dying that faced her, its quality and nature, and the state of utter dependence that it involved, were unacceptable to her. They violated her fundamental values and her sense of dignity as a person.

*Kluge 2:13*

That is the whole issue — the freedom for that person to choose and to define what is tolerable and not tolerable for them...We have to expand our minds to allow ourselves to see what suffering is to somebody else and acknowledge that suffering.

*Seguin 7:44-45*

The Unitarian Council explained that when disease has resulted in a loss of dignity for individuals, it is merciful to allow them to die if they so wish it:

It is our Unitarian view that the current law, which does not permit assisted suicide, is both inequitable and lacks compassion. It is unfair to force someone to live when they no longer wish to continue living. A law which does not allow for each individual's request for assistance lacks compassion. Under this principle, Unitarians assert that the law must be changed to treat with compassion the clearly stated desires of those individuals who feel that their irreversible illness has eroded the dignity and the value of their lives.

*Kiely 14:62*

Some witnesses emphasized that Canadian society deeply values freedom of conscience and religion, as well as diverse cultures, to the extent that they have been enshrined in the *Canadian Charter of Rights and Freedoms*:

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We affirm the right of conscience and the use of the democratic process within our congregations and in society at large. This principle also reflects a dynamic tension between the rights of the individual and the rights of the community. We have already stated that... no one has the right to dictate another's beliefs or values. We uphold the right of each member and friend of our societies to speak her or his mind on any matter of conscience, for we believe the open sharing of values and ideas can only further our debate.

*Kiely 14:62-63*

Some witnesses raised the issue of equality: because it is not illegal to commit suicide they argued, the only people who cannot commit suicide as a result of the law are those not physically able to do so. As Martin Campbell of Dying with Dignity expressed:

The [situation] of Sue Rodriguez shows how the present law discriminates against the disabled. I can commit suicide because I am physically able to do so, but someone who cannot, because of medical conditions or otherwise, is prohibited from making that choice.

*Campbell 7:21*

This concern for equality was related to the argument that to maintain the criminalization of assisted suicide might induce individuals with a debilitating illness to commit suicide earlier than they might want. As Professor Kluge remarked:

The *Criminal Code* sometimes forces the individual to buy the retention of her or his dignity, but only at the price of a hurried and premature taking of life, a barrier that sometimes forces an undignified, horrifying and appalling dying on the individual person in the name of protecting the personhood of that very individual.

*Kluge 2:9*

Some witnesses argued that decriminalizing assisted suicide would actually reduce the number of requests for assisted suicide. They said it would provide people with a form of psychological insurance, reducing concern about the possibility of a painful and undignified death. Professor Schafer, Sheila Noyes and Dr. Buckman all addressed this point:

It may be that only a small number of Canadians would ever, when it came to the point, require the assistance of a physician to end their lives. But a very large number of Canadians, Madam Chair, would take great comfort, and have confidence and security in the knowledge that, if they were in a position to need it, they could receive assistance from a sympathetic physician to die in a way that seems dignified to them.

*Schafer 18:29*



Those who are terminally ill with a debilitating illness which renders them totally helpless must have a choice. They need to know that before they reach the point of unendurable suffering, they can choose to have a swift, peaceful and certain death. I believe that the knowledge that this is available to the terminally ill would immeasurably enrich their final months by removing the terror. It would allow them to fight their illness for as long as possible, and to enjoy the days they have left with their families.

*Noyes 18:7*

Assisted suicide is like the emergency exits or life jackets on airplanes. The number of times they will be used is very very few indeed; however, absolutely everybody who flies on an airplane is glad to see them there. If someone said that you could get on their airplane but that there were no life jackets or emergency exits, most people would feel very nervous.

*Buckman 26:4*

The Committee heard testimony about the consequence of failed suicide attempts. Mr. Ogden and others illustrated this occurrence:

A dominant feature of many of these deaths was the abysmal, horrific circumstances in which they took place. ... The intent is a quick and easy death but it does not always work that way. Psychic scars that are left on the survivors are immeasurable.

*Ogden 14:76*

This practice [suicide] is going on today and it is going on largely covertly, sometimes with the assistance of physicians, sometimes not. I fully agree with Russell Ogden's finding that many of the individuals who attempted to end their lives without physician assistance did so badly, further exacerbating pain and suffering.

*Rowand 9:37*

Some witnesses said that the slippery slope could best be avoided and the vulnerable best protected by the strict regulation of assisted suicide, since they say it is already taking place despite its illegality. Mr. Bureau, for example, stated:

As a result of a strict framework for practice and guidelines for the protection of the dying person, there will be far fewer abuses of euthanasia and assistance in self-euthanasia [assisted suicide]. In my view, it is far preferable to have a certain tolerance of this practice under exceptional circumstances in an open system than to prohibit it officially while allowing it to be carried out in a secret, clandestine system often beyond any form of solidarity or control. There are often fewer abuses in an open, unambiguous, supportive, sympathetic system that respects the person involved.

*Bureau 4:36*

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Dr. Boadway made the point that it is better to discuss openly and regulate such incidents, rather than allow assisted suicide to occur clandestinely:

I believe the people of Canada would best be served by a recommendation that decriminalized the process that is occurring daily across this country, following the full and proper consultation between physicians and patients. It is possible to develop a process to ensure that free and open decisions are made, and to define when either euthanasia or assisted suicide could take place without the fear of abuse. The law as it stands is not enforced or enforceable. It is therefore incumbent on you to change the law to something that will both reflect the values of Canadians and be meaningful to society and the courts.

*Boadway, 20:77-78*

Ms. Mullens described the consequences of failing to change the existing law:

What will happen if governments do nothing? I think there will be increasing challenges to the legislation, but juries and judges will become increasingly reluctant to commit. The law will become unenforceable or meaningless. ...The situation will be wide open, with no scrutiny, no record keeping or formal system of compliance...That, I think, is the real slippery slope.

*Mullens, 30:6*

Some witnesses argued that assisted suicide should be decriminalized because public opinion polls have repeatedly shown that most Canadians favour permitting assisted suicide:

If national polls are accurate, an increasingly strong majority of Canadians are demanding such legalization.

*Kiely 14:63*

Legalization of physician-assisted death, as sketched before in terms of using palliative care consultants and palliative care committees, recognizes patients' rights of autonomy, respect for persons, protection and support for physicians, and appears to be in congruence with the opinions and beliefs of the general public.

*Verhoef 18:85*

A few witnesses made the argument that if treatment provided to alleviate suffering that hastens death and withholding and withdrawal of life-sustaining treatment are accepted, then assisted suicide should also be accepted. Mr. Considine, counsel for Sue Rodriguez, made the following comment:

We already recognize patient choice with respect to the cessation of life when a patient states that he wishes to be disconnected from life support systems or that he does not wish to have life support systems applied. Those are conscious decisions made by the patient when the patient is competent and after the options have been explained by physicians. We already do it.

We also do it to some extent with palliative care. We recognize that the principle of palliative care is to relieve the mental and physical suffering. We also recognize that a secondary effect may be the hastening of death.

If we recognize that the patient may have the choice with respect to those particular options, then, considering a patient who is in very similar circumstances in the sense of being terminally ill, who is competent, who has had all the options explained to him and the physician is satisfied he understands those options, surely that patient also ought to be able to have physician-assisted suicide as another option for dealing with the final stages of disease.

*Considine 14:20*

Professor Schafer also maintained this position:

None of the arguments - not this argument [re: the difficulty of ascertaining competence] and none of the other arguments you have heard - is more decisive or stronger against euthanasia or physician-assisted suicide than it is against what, at the beginning of my presentation, I called "indirect euthanasia" or "palliative care" or "passive euthanasia" or "appropriate care".

*Schafer 18:130*

## Committee Deliberations

In its submission, the *Canadian Bar Association* summarized the dilemma facing the Committee:

The questions of euthanasia and assisted suicide raise fundamental issues of public order or policy with which each court presented with such a case has had to grapple. Much of Canadian law, like the society it reflects and upholds, is devoted to protecting the vulnerable, and protecting human life generally; the sanctity of human life is a fundamental principle on which much of our legal tradition is based. There are other public interests at stake, as well, such as protecting the medical profession from loss of trust or integrity. At the same time, our legal system is devoted to protecting and defending rights of individuals to make their own decisions, and hold their own opinions, however radically they may differ from those of society around them.<sup>18</sup>

The members were asked to ponder many aspects of life and death, including life as a fundamental value in any society, autonomy as an individual value, and suffering as a reality generally associated with the end of life.

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18 Submission of the Canadian Bar Association, pp. 4-5.

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In a number of areas, the same values were embraced by witnesses on both sides of the debate, but there was disagreement on how best to achieve them. The Committee considered Dr. Mount's comments:

I do not think that this is a national debate about death with dignity because I would suggest that people who would come down on both sides of the question would favour death with dignity. Second, I do not feel this debate is helpfully characterized by either pro-life or pro-choice alternatives. Again, I feel that people on both sides of the question would see themselves as holding both views. Third, I think this debate is not about discontinuing or withholding inappropriate life-prolonging treatment, an issue that has been under debate in our country and others for some three decades and on which consensus has largely been reached...Fourth, this debate is not about double effect. That is the risk of shortening life as a consequence of treatment given for the purpose of alleviating suffering. That may happen as a consequence of good palliative care and it is unrelated to euthanasia or assisted suicide. Fifth, I think this debate is about the best response and the best way for Canada as a nation to respond to the sort of suffering we have heard about.

*Mount 5:26-27*

Throughout the course of its hearings, the Committee heard a wide range of viewpoints from the more than one hundred and fifty witnesses who appeared before it. Although the Committee had no difficulty on reaching a consensus on matters discussed in earlier chapters, there was a considerable difference of opinion on the issue of assisted suicide. The Committee considered a complex set of interrelated factors: the dying person, the family, the social environment, the present medical practice and the provision of various health care services. It had heard that a small percentage of Canadians in the final stages of dying do not wish to prolong their illness, either because they fear or are undergoing unrelievable suffering or because of the loss of dignity and the loss of control over the process of dying.

The Committee members hold differing views as to how society can best deal with the suffering of these individuals. While they recognize the different ethical arguments and points of view, all of them have deep concerns about the implications of permitting assisted suicide.

They also recognize that the values of individual autonomy and the interests of society can at times be in conflict and that, in some circumstances, individual autonomy must be restricted in the interests of society. Some members feel that aid should be provided to the dying in ways other than assisted suicide because they believe that the societal interest in upholding the respect for life must prevail. Other members think that intolerable suffering justifies providing assistance in committing suicide. The Committee agreed, however, about the need for tolerance and respect for opposing points of view.



### **Committee Members' Views Opposed to Changes to the Existing Legislation**

The members opposed to changing the existing legislation with respect to assisted suicide are primarily concerned with maintaining the fundamental social value of respect for life. They feel that legalizing assisted suicide could undermine respect for life which they believe is the most universally accepted value in society. Few democratic societies permit assisted suicide. In a pluralistic society, respect for life is a societal value that transcends individual, religious or diverse cultural values.

These members are also concerned about the risks associated with changes to the present law. In their view, legalization could result in abuses, especially with respect to the most vulnerable members of society. The ill and the frail are particularly dependent on those around them and on the health care system. Inevitably, and often without realizing it, these individuals cede control over their lives to the system and to those on whom they are dependent. For this reason, it would be difficult for others to assess whether an informed choice was made without coercion. If assisted suicide were legalized and accepted by the community, how could the expectations of the people surrounding the patient not influence his or her decision, particularly if the patient feels she or he is a burden on the family.

They think that some would feel pressured to resort to assisted suicide where financial and institutional resources are scarce. Financial restraints that affect the health care infrastructure could also result in attempts, perhaps unconsciously, to influence patients to die more quickly and conveniently. All of the above factors could make it difficult to establish whether a request for assisted suicide is voluntary.

There was also some concern over the issue of the "slippery slope". Changes in the law with respect to competent persons could lead the way to possible changes in the law for incompetent persons.

Some of these members think that if assisted suicide were to be decriminalized but voluntary euthanasia remain a criminal offence, the effect would be a law that might create an inequality contrary to section 15 of the *Charter*. Those who are physically incapable of committing assisted suicide would be prevented from ending their lives when that option is, in principle, available to others. These members would prefer upholding the prohibition on assisted suicide rather than risk opening the door to euthanasia.

The ability to adequately control, monitor and enforce the most stringent safeguards on assisted suicide was a further consideration for these members. The Netherlands experience illustrates that guidelines are not always followed. They believe a society cannot adopt a policy permitting assisted suicide without initiating a process that may be difficult to control.

Some of these members note that individual autonomy cannot be absolute because individuals need each other in order to realize their goals, and likewise the actions of individuals have an impact on other people close to them and on society as a whole. Individual rights must be limited to the extent that they cause harm to other persons.

While disallowing assisted suicide may seem unfair or harsh in an individual circumstance, this is outweighed by the negative impact that decriminalization would have on the popular conscience. How can society say that assisted suicide is a valid course of action without sending the message that suicide is appropriate? Since we are aware of an unacceptably high rate of suicide among young people, especially in the aboriginal community, how can we justify any action that suggests assisted suicide is a legitimate response to suffering? Accepting decriminalization would trivialize death and lead to a view of death as a solution to problems.

In addition, these members are of the opinion that dying with dignity is not simply a matter of controlling the time or means of death but involves the right to receive, up to the end, the care needed to relieve one's suffering and to be surrounded by human attention and compassion. It is the right to feel one still has value as a person. Dignity exists when one faces the final stages of life with a feeling of self-worth and with the care, solicitude and compassion to which all human beings are entitled.

Among these members, some feel more research in the area of assisted suicide is required. They are of the view that the lack of available information would make it difficult for them to support a change in the law with respect to assisted suicide at this time but would not preclude a consideration of it at a later date.

### **Committee Members' Views in Favour of Changes to the Existing Legislation**

The members in favour of changes to the law were influenced by the testimony, and the many letters the Committee received, describing the pain and suffering of persons with debilitating and irreversible illnesses. They are concerned with the loss of autonomy experienced by many individuals because of their condition. This loss can be aggravated by a paternalistic attitude of some health care professionals and institutions exerted over individuals in their care. While these members recognize the value and potential of better palliative care and optimum pain control, there is still a small percentage of ill and suffering patients for whom these measures would not alleviate their pain and suffering. The figure most often cited by the witnesses in this regard was five per cent.

Nevertheless, these members believe that relatively few within this most difficult category would choose the option of assisted suicide if it were available. Many would simply be comforted by the knowledge that assistance in their suicide would be permitted, if they should feel the need for it. This would give them control over their lives and so protect their right to autonomy and alleviate their fears of suffering.

These members are of the opinion that the Hippocratic Oath should not limit physicians in terms of their role in society. The practice of medicine, our laws and our cultural norms have evolved tremendously over the centuries. Although many doctors characterize themselves as "healers", their function should encompass much more. Their role is, or should be, to care and comfort the ill and also to alleviate their suffering. Where the pain and suffering of the irreversibly ill cannot be alleviated by any means, they should have the option of requesting assistance in committing suicide.

Notwithstanding the decision in the *Rodriguez* case, some of these members believe that the existing criminal law provisions create an inequality under section 15 of the *Charter*. They said that while section 241 (b) of the *Code* appears to be neutral in its application, its effect is not. It prevents persons who are physically unable to end their lives without assistance from choosing suicide when that option is available to others who do not require assistance, without contravention of the law.

They feel that we are already on a type of “slippery slope”. They believe that, at present, assisted suicide is taking place despite its illegality and it is occurring without adequate controls. Thus there is more potential for abuse because there is a greater risk to the vulnerable from unregulated medical assistance at the end of life, than from legislative changes accompanied by appropriate safeguards. To insist upon maintaining the status quo for fear of the effect of change could very likely result in greater harm than thoughtful and carefully drafted exemptions from our current criminal law provision.

Therefore, these members would favour an exemption to the *Criminal Code* that would permit persons to assist in a suicide under clearly defined safeguards. The Minister of Justice, in cooperation with his provincial and territorial counterparts, should engage in discussions with the Canadian Medical Association and the other national bodies that regulate the health care professions in order to develop such safeguards. They should, at a minimum, include the following elements:

- The individual must be competent and must be suffering from an irreversible illness that has reached an intolerable stage, as certified by a medical practitioner.
- The individual must make a free and informed request for assistance, without coercive pressures.
- The individual must have been informed of and fully understand his or her condition, prognosis and the alternative comfort care arrangements, such as palliative care, which are available.
- The individual must have been informed of and must fully understand that he or she has a continuing right to change his or her mind about committing assisted suicide.
- A health care professional must assess and certify that all of the above conditions have been met.
- No person should be obligated to provide assistance with suicide.

These members believe that regulations must be established in order to deal with the monitoring and enforcement of the safeguards by the appropriate level of government and that records must be maintained of all applications for and instances of assisted

## **Assisted Suicide**

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suicide. In order to avoid abuse, the safeguards must provide for review both prior to and after the act of assisted suicide.

In the event that the government decides to consider the recommendations of these members, they urge that the necessary safeguards accompanying the legislation be made available, at least in draft form, to all members of Parliament before the proposed legislation is debated.

### **Recommendations**

**The Committee recommends no amendments be made to the offence of counselling suicide under subsection 241 (a) of the *Criminal Code*.**

**A majority of members recommend subsection 241(b) of the *Code* also remain intact.**

**A majority recommends research be undertaken into how many are requesting assisted suicide, why it is being requested, and whether there are any alternatives that might be acceptable to those who are making the requests.**

**A minority recommends an exemption to subsection 241 (b) of the *Criminal Code* be added, under clearly defined safeguards, to protect individuals who assist in another person's suicide. These safeguards should include, at a minimum, the elements listed in this chapter under "Committee Deliberations". They further recommend, that in order to avoid abuse, procedural safeguards must provide for review both prior to and after the act of assisted suicide.**



## Chapter VIII

### Euthanasia

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The Committee has defined euthanasia as *the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person's suffering where that act is the cause of death*. It is euthanasia, for example, if someone administers an individual suffering from amyotrophic lateral sclerosis (ALS) a lethal substance.

Euthanasia is *voluntary* when it takes place in accordance with the wishes of a competent individual, whether these are made known personally or by a valid advance directive. An example would be when a health care professional gives a lethal substance to a patient who is both competent and suffering, at that patient's request.

Euthanasia is *nonvoluntary* when it is done without the knowledge of the wishes of a patient either because he or she has always been incompetent, or is now incompetent and has left no advance directive. An example would be when a daughter smothers her incompetent father who is suffering from advanced ALS, but who did not make his wishes known while he was competent.

Euthanasia is *involuntary* when it is done against the wishes of a competent individual, or against the wishes expressed in a valid advance directive. An example would be when a nephew gives a lethal injection to his competent uncle who is suffering from cancer but does not want the injection.

### Legal Status

Under the *Criminal Code* all forms of euthanasia are illegal in Canada, as well as in all other jurisdictions, except in the Northern Territory of Australia.<sup>19</sup> Acts of euthanasia are either first or second degree murder in Canada, although they may be and have been prosecuted as offenses other than murder.<sup>20</sup>

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19 For a more detailed discussion of the current legal situation regarding euthanasia in selected countries, see the Appendix P to this Report.

20 The full text of the provisions of the *Criminal Code* that may be applicable in cases of euthanasia have been reproduced in Appendix F to this Report.

## Euthanasia

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Our criminal laws are based upon intention, not motive. Motive only becomes relevant at the sentencing stage where no mandatory sentence is provided. The fact that the motive in acts of euthanasia is to alleviate suffering is immaterial in terms of the imposition of a charge. The written submission of the Canadian Bar Association provides:

In the Canadian system, motive (as distinct from the intent to do the acts in question) has never been relevant to the elements of an offence; that is, it has never been a factor in finding criminal liability...Traditionally, motive has gone to issues of sentencing, not to the elements of an offence.<sup>21</sup>

Although under our present criminal law cases of euthanasia should be charged and prosecuted under first or second degree murder, in practice this is seldom the case. Often they are not prosecuted in a consistent manner because of the potential difficulties in securing a conviction. This may result, with respect to the same factual situation, in no charges being laid or in charges ranging from administering a noxious substance to first degree murder.

Due to the inconsistencies in the charging of such cases, the sentences for the same conduct can range from probation and community service to life imprisonment with no possibility of parole for twenty-five years.<sup>22</sup> Since the charges are usually for lesser offenses, the sentences have in most cases been relatively light. Furthermore, the courts in sentencing have tended to consider, not only the motive for the commission of the offence, but also such factors as a request to die made on the part of the deceased.

The Deputy Chief Coroner of Ontario, Mr. Jim Cairns, informed the Committee about the inconsistent manner in which euthanasia cases are being prosecuted and sentenced. He described three recent Ontario cases in order to illustrate this:

The first case involved a son who increased a morphine infusion on his father in a hospital. His father was dying of cancer, and the son had made a pact with his father that he would not let him rot away for three or four days, but would increase the morphine... When it was reported to our office, it was clear...that the son had had the deliberate intention of increasing the morphine, with the deliberate intention of killing his father... He pleaded guilty to mischief likely to endanger life and was given probation.

The second case...[involved] a nurse injecting potassium into a patient. In that case, initially the nurse was charged with first degree murder... That nurse eventually pleaded guilty to the administration of a noxious substance, was

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21 Submission of the Canadian Bar Association, March 1995 p.12.

22 For examples of inconsistencies in the charging and sentencing in euthanasia cases, see the summaries of relevant Canadian court decisions found in Appendix L to this Report.

given a three-year suspended sentence, and voluntarily agreed not to be involved with nursing or health care ever again.

The final case involves a doctor who injected potassium into a patient. At a preliminary hearing, the doctor was charged with second degree murder... This involved a prominent surgeon in a community where the doctor had done a lot of good work. The concern was: Would a jury convict someone of second degree murder — that is what the present law states — or would they find him not guilty and would we, by default have a situation where the present law was not being upheld? Due to a number of situations that arose, the doctor agreed to plead guilty to the administration of a noxious substance and received a suspended sentence.

*Cairns 20:7*

In referring to the legal status with respect to euthanasia, Professor Bernard Dickens, of the Faculty of Law at the University of Toronto, explained:

The limitation of the existing murder provision is that by the *Criminal Code* the minimum punishment for murder is life imprisonment. We distinguish first degree murder from second degree murder not by reference to the sentence but by reference to eligibility for parole; that is, those convicted of first degree murder cannot, with exceptions, be eligible for parole in less than 25 years. Those convicted of the only alternative, second degree murder, are not eligible for release in less than 10 years. Prosecutors at times seem to find this too harsh, and juries again seem to have reservations about imposing sentences they consider excessive.

*Dickens 10:31-32*

### **British Columbia Crown Counsel Policy Guidelines**

As was stated in the previous chapter, the British Columbia Ministry of the Attorney General is the only province at present that has issued guidelines for the exercise of prosecutorial discretion in cases where “a police report reveals a person, motivated by compassion for the deceased, participated in causing a death”. These guidelines provide that a medical practitioner will not be subject to criminal prosecution for active euthanasia unless there is a substantial likelihood of conviction and the public interest requires a conviction.

### **Points of View of Witnesses**

Many of the witnesses had reflected on the difficult questions surrounding euthanasia in light of their own personal experiences. The impact that this had on their lives affected their views on the subject to a great extent. Ms. Noyes related her thoughts to the Committee:

I learned much through watching the suffering of my mother. I learned that only one person feels the physical pain and that is the dying person...Surely it follows that only that person can determine whether or not life under such circumstances is worth living...It is as morally unjustifiable to deny people the right to assist someone to die as it would be to compel people to take this course against their wishes.

*Noyes 18:6*

Mr. Walter Lawrence, who appeared with the Evangelical Fellowship of Canada, told the Committee how his experiences after a diving accident that had left him quadriplegic influenced his opinion on the issue:

I think it is inherent in all of us to be able to contribute, to give to one another. What we so often do is frame the way we can contribute in a small way...Once it is gone we feel that there is no contribution to be given. It was at that time — and, believe me, I talked about it [suicide] a lot to a lot of people — these people could have said, “Well, yeah, Walt, your life is really of no value, so why don’t we help you and assist you toward your desire to end your life?” They did not do that. Thank God, they did not.

*Lawrence 15:63*

Some witnesses testified as to the incidence of euthanasia in Canada, although there was some disagreement among them on this point. For example, Dr. Wyman, President of the Ontario Medical Association, speaking for himself and not for the Association, stated:

I have spoken with physicians who have been involved directly in the process. I know for a fact that it does occur on a regular basis. Those who say that it does not are either not talking with many physicians or deliberately turning a blind eye to the numbers.

*Wyman 20:81*

Mr. David Thomas, a crown attorney from Timmins, Ontario, told the Committee:

In the course of my case, it became apparent that euthanasia goes on routinely across Canada, both passive and active, under the guise of aggressive palliative care. Even as we are speaking someone is probably being euthanized, and most often it goes unreported and undetected. Even in the case that I handled, the chances of it being detected were extremely remote.

*Thomas 29:41*

Dr. Gordon Crelinsten, of the Royal College of Physicians and Surgeons of Canada, informed the Committee that:

Voluntary, intentional acts to cause death within the hospitals at which I have practised in the province of Quebec, are extremely rare if not non-existent.

*Crelinsten 20:40*



Similarly, Dr. Kinsella testified:

I graduated from medicine in 1957, and I practised in Quebec, in Ontario, in Dallas, Texas, and I practised in Alberta. Quite honestly, I have never personally encountered a physician, either formally or informally, who was engaged in what I would consider to be, according to the definition I have given you, active euthanasia or assisted suicide. I know there are physicians around who say it is more common than we all think, but if it is, I do not know where it is taking place.

*Kinsella 16:14-15*

The Committee found various legal, ethical and social arguments were addressed by the witnesses both against and in favour of euthanasia. They often mirrored those that had been expressed on the issue of assisted suicide, although there were a few that applied more specifically to euthanasia.

### **Witnesses Arguments Against Decriminalizing Euthanasia**

The fundamental value of life was raised by certain witnesses as the primary reason for not allowing euthanasia. Archbishop Bertrand Blanchet, of the Canadian Conference of Catholic Bishops, explained:

The justice of a society finds its measure in the ability to further and protect the lives of its members, given that life provides the basis for all other good in society...The legal, philosophical and religious traditions of the West have stressed defending life against any and all assaults.

*Blanchet 22:45-46*

Dr. McGregor stated:

We have an edict that our society is based on which says you do not kill. Can you take that and make special exception to a basic principle of society and say, "Do not kill, yes, but in this situation you can." I am not sure that if you do that, you do not start a whole cascade of things that may complicate life far more than it is already.

*McGregor 4:59.*

Some witnesses were of the opinion that legalizing euthanasia might pressure certain vulnerable groups who feel they are a burden on others. Dr. McGregor and Dr. Latimer supported this view:

Frail, dependent and vulnerable people often feel valueless and that they are an undue burden on those who love and care for them, perhaps even on society, as some patients have said to me. Such persons may feel compelled to request euthanasia should it be legalized.

*McGregor 4:53*

## Euthanasia

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It is not unusual for people who are seriously ill to feel they are a burden on others, particularly those who care for them, and we have grave concerns that people would begin to feel that the most valiant way would be to ask to have their lives ended. Subtle pressures may ensue in that way.

*Latimer 4:7*

Others believed that permitting voluntary euthanasia would place society on a slippery slope, as did Dr. Roy:

People in favour of euthanasia tend to argue that it would only be given to those who ask for it with clear, lucid, free, uncoerced consent. It would be difficult for a society to withstand for long the pressures — once voluntary euthanasia is acceptable — to move on and to give euthanasia to those whose lives seem to have no sense, no purpose, no worth in the eyes of the others.

*Roy 22:9*

A number of witnesses expressed concern that economic considerations with respect to the provision of health care might influence decisions about euthanasia if it were decriminalized:

Since the health care system is costly in the various Canadian provinces it could be tempting to solve this economic problem by killing our elderly, the bedridden and the confused who occupy beds in our hospitals. And we should not deny it: although things have changed in recent years, the elderly are not that welcome in the world of caregivers in our hospitals. It is often said that they take up space, that they take up too much space and that they take up beds.

*Carrier 3:9*

Respect and support for the chronically ill and disabled also raise the worrying possibility that euthanasia could be covertly linked to limited health care resources. No public policy on euthanasia would ever be proposed on the basis of saving money, but, once such a policy were in place, who can say that financial concerns would not become a consideration within facilities and agencies or even within families?

*Brief, Canadian Nurses Association, p.8*

An important point...is the economic conflict of interest that the medical profession is involved in when it comes to euthanasia. The BCMA [British Columbia Medical Association] is involved in negotiating for funds, and we are living under a capped budget. If we overrun this budget, the excess dollars come out of the pockets of the physicians of British Columbia. This pro-ration model is the same model used in most provinces in our country. If euthanasia were legalized and it could be demonstrated that euthanizing patients would save money for the system, then the medical profession would find itself in a conflict of interest between patient care and pro-rationing.

*Lane 14:26*

There was a concern that vulnerable groups would be most susceptible to these economic pressures. The availability of euthanasia may exert subtle pressures on such groups to request it, feeling themselves a burden to society:

We fear that, by legalizing euthanasia, society's social and economic pressures could force the aged, the infirm and the incompetent to have to give daily justification of their right to live. It would be a tragedy if, in changing the legislation to legalize euthanasia as an act of mercy, we condemned a segment of our community to excusing their decision to live and to occupy a place within the health care system.

*Thompson 14:52*

Some witnesses said that suffering can be meaningful and can provide an opportunity for personal growth if the individual is surrounded by family and friends.

It is possible to give support and comfort during suffering that makes it bearable and gives it meaning. The dying process can be transformed into a meaningful event, livable and bountiful. It is possible to create an environment to which someone who is both ill and in pain, and has reached the terminal phase of his illness, can go to live rather than go to die, where he will meet a team that will support him, including his family...It is also possible to transform the dying process into a natural event in personal growth. During the dying process the individual can live and grow as a human being instead of just declining physically, as often happens. We counterbalance physical decline with comfort, serenity and love - since the team works within the family, in a context where friendship, love and respect flourish.

*Dionne 13:6*

Others said that the final stages of life of a patient can sometimes bring the patient, the family and friends closer together:

Nurses who work with the chronically and terminally ill often believe that there is value in living life to its natural end. Nurses have told us that the knowledge of approaching death brings people together as human beings and allows the patient to learn and feel a sense of resolution. Family members sometimes experience the final days, weeks or months as a precious time in which they have the chance to express their love and deepen their appreciation of their loved ones.

*Canadian Nurses Association 19:5*

Many health care professionals were concerned about the possibility that their participation in voluntary euthanasia would undermine the relationship of trust between the patient and the physician. Mr. Carrier held this view:

There would also be a risk that the general public would lose trust in health professionals and in our institutions. Who will guarantee patients that their doctors will never practise euthanasia when they are terminal?

*Carrier 3:10*

Similarly, Dr. Lane testified:

We, as doctors, are very privileged to have entrusted to us the concerns, the care and the words of our patients. We realize how fragile this trust is, and how easily it can be undermined when we are not doing what is in the best interests of our patients. Euthanasia jeopardizes the doctor-patient relationship.

*Lane 14:25*

### Witnesses Arguments for Decriminalizing Euthanasia

Some witnesses stressed the rights of individuals to choose the timing and manner of their death:

My basic view of this is fairly clear-cut, that is, each of us is master of our own fate and we have the right to choose our own demise.

*Wallace 15:89*

Others felt that euthanasia is a merciful and appropriate response to suffering:

When requested, I see euthanasia as a positive Christian act; a moral act, not something that must be apologized for. "Blessed are the merciful for they shall obtain mercy" weighs far more with me than the intense effort of saying that life and suffering teaches us something. Suffering does teach us something, but there comes a time when there is no more to be learned by the patient or by the people who love the patient.

*Dickey 8:58*

Others went further and stated that the unrelievable pain and suffering of individuals is the justification for the decriminalization of voluntary euthanasia. Mr. Alister Browne, on behalf of the British Columbia Civil Liberties Association, stated:

There are many arguments for legalization, but the one which strikes us as being the most powerful, clear and direct goes as follows: We have a right to minimize our suffering; we have a right to preserve our dignity. Sometimes we can only do those things by dying, and sometimes we need help to die.

*Browne 14:126*

Witnesses told the Committee that the availability of voluntary euthanasia would provide a sense of security and reassurance to people facing death, even if it were never used. Reverend Kiely shared his personal experiences with the Committee:

What my mother does fear is pain...she does not trust doctors too much. Her doctors have promised her the best of pain management and expressed confidence that she will not suffer unduly, but she does not believe it. She is still worried. What does seem to have calmed her is a promise that I made to her that, should it all become unbearable, I will end her life...In truth, because of my mother's character, her courage, and her own religious beliefs, I doubt that I will ever be called upon to do this. I can say with confidence, because she just told me, that simply knowing that there is an out if it gets too bad has given her peace of mind and has eased her suffering.

*Kiely 14:65*



Some witnesses felt that in a pluralistic society, a person's views should not be imposed on others. Dr. Donald Bailey, President of the Manitoba Association for Rights and Liberties, testified as follows:

The state has no business imposing someone's religious position. But you can respect it. If you are opposed to certain kinds of moral behaviour, that is fine. You do not have to condone it, but you should not deny another person the right to that choice if that other person wants to do that.

*Bailey 17:33*

There were some witnesses who stressed that since they believed euthanasia is occurring at present, it is better to regulate it in order to minimize abuses:

I do not think continuation of a practice that ignores the reality that this exists is in the interest of patients or the public. Some regulation is better than an ostrich approach where we continue to deny that this exists.

*Rowand 9:38*

A number of witnesses referred to the public opinion polls taken over the last few years in order to make the point that Canadians seem to consistently favour some form of aid in dying:

More than 70 per cent of respondents in surveys in Canada said they were in favour of assistance in voluntary dying for dying patients; more than 80 per cent were of the same view in Quebec.

*Bureau 4:36*

It will be very difficult for the Government of Canada to make legislative change in this area. Yet, if you are talking about society, and if you believe the polls, then 78 per cent of Canadians feel that they should have it.

*Mullens 30:15*

Some witnesses stated that there is no significant difference between euthanasia, on the one hand, and other end of life decisions, such as withholding and withdrawing of treatment and providing treatment to alleviate suffering that hastens death, on the other:

On the whole, we seem to manage pretty well in determining patient competence in order to make palliative care decisions and to make end-of-life decisions about withdrawing and withholding medical treatment. I cannot see why it would be more difficult, more problematic, more dangerous or more abusive to allow patients to make similar decisions on whether they, as in the case of Sue Rodriguez, require the assistance of a physician to end their lives.

*Schafer 18:130*

Ms. Monique Coupal, of the Fédération québécoise des centres d'hébergement et de soins de longue durée, in response to the question of why some favour a change in the law on assisted suicide and euthanasia, informed the Committee:

The directors of nursing care and the caregivers who have told us that they are uncomfortable with the situation and would like to see the law amended, feel compelled to consider these issues in the face of suffering that can no longer be adequately alleviated or wonder about the distinction between euthanasia and respecting a patient's right to refuse treatment, which can go so far as halting all food and fluids, which will lead to death.

*Coupal, 32:51*

### Committee Deliberations

The following excerpts illustrate the different views of the Committee members considered in their study of euthanasia. The Law Reform Commission's 1982 Working Paper provides:

The protection of human life is a fundamental value in all legal systems. Law, whatever its specific variations and particular cultural, political or social context recognizes this value to various degrees by forbidding homicide and punishing acts which constitute a danger or serious threat to the lives of other human beings. The preservation of life is not, however, an absolute value in itself, even for the Canadian legal system. If it were, of course, attempted suicide would not have been decriminalized, nor would self-defence be recognized as legitimate.<sup>23</sup>

Mr. Justice Sopinka, in the *Rodriguez* decision, expressed the view that while there is a consensus that human life must be respected, there is support for the view that the quality of life is an essential component of this principle:

The principle of sanctity of life is no longer seen to require that all human life be preserved at all costs. Rather, it has come to be understood, at least by some, as encompassing quality of life considerations, and to be subject to certain limitations and qualifications reflective of personal autonomy and dignity.<sup>24</sup>

Five members of the Canadian Bar Association who submitted a separate brief on their own behalf to the Committee in March 1995, in referring to the issues of assisted suicide and euthanasia, concluded as follows:

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23 Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment*, Working Paper 28, p.3.

24 *R. v. Rodriguez* p. 595.

Regardless of how one sits at the end, we are ultimately faced with inadequate protection from abuse, the need for better care of the dying including education and management of pain, and the need for more public dialogue about the real limits to death and dying in our society. Failure to legalize euthanasia and assisted suicide does not end the search for better and more adequate solutions to the plight of the hopelessly ill and dying members of our community.<sup>25</sup>

### *Nonvoluntary Euthanasia*

There are many types of medical decisions that may be considered nonvoluntary euthanasia. Such cases involve incompetent persons whose wishes are not known. Persons in persistent vegetative states and severely disabled newborns may fall under this category. Although the Committee received very little evidence on these matters, it recognizes that such cases pose great problems for health care professionals and family members faced with the task of making decisions for patients who are not able to express and have never expressed their wishes. These cases require more clarification and study and the medical profession should play a leading role in dealing with them.

The Committee, however, discussed cases commonly referred to as “mercy killings”. It believes there are some inadequacies in terms of the application of the present *Criminal Code* provisions as they apply to cases where compassion or mercy is the motivation for terminating an incompetent person’s life who is suffering from intolerable pain in the final stages of life. Under existing law, cases of nonvoluntary euthanasia ought to be prosecuted as first degree murder since the death is planned and deliberate. The penalty for first-degree murder is imprisonment for life, with no eligibility for parole for twenty-five years.

The members are of the view that there is a difference between a killing motivated by compassion or mercy and other forms of murder. Juries are often reluctant to convict in cases where the crime is motivated by compassion or mercy and in particular when they involve someone who is in the final stages of his or her life. This often leads to plea bargaining resulting in a charge of a lesser offence or to a suspected offence not being prosecuted. Thus, the actual practice of the law does not coincide with the letter of the law. The members, therefore, believe a less severe penalty should be imposed than is presently provided in the *Criminal Code* in cases involving an element of compassion or mercy. These elements must, however, be clearly defined and limited.

### *Voluntary Euthanasia*

The Committee could not ascertain the extent to which voluntary euthanasia takes place principally because people are reluctant to speak openly about illegal actions; however, the Committee was informed that requests are made by individuals and that premature deaths do occur in order to end suffering.

The Committee agrees that there is no justification for failing to alleviate controllable pain and suffering. The issue upon which there was disagreement among the members is the most appropriate way to address the needs of those for whom pain control is ineffective.

Another issue with which the Committee was consistently confronted was the question of how to balance two different interests: individual rights and the interests of society. To what extent can the individual rights of autonomy and self-determination be protected without compromising society's interest in upholding the principle of respect for human life?

The Committee members were not always in agreement on how these and similar questions should be answered and their recommendations reflect these differences.

### *a) Views of Committee Members Opposed to Voluntary Euthanasia*

The majority of these members oppose voluntary euthanasia for the same reasons they oppose assisted suicide but they also have an additional objection in the case of voluntary euthanasia. They are of the opinion that there is a fundamental difference between assisting suicide and performing euthanasia; in assisted suicide, it is the dying person who is the principal agent of death while in acts of euthanasia, the agent is another person. Since a second person is directly involved in the case of voluntary euthanasia, they do not believe adequate safeguards could ever be established to ensure the consent of the patient was given freely and voluntarily. This is essential in order to prevent abuses and to avoid opening the door to nonvoluntary euthanasia.

The majority of these members reject both assisted suicide and voluntary euthanasia. They believe that if assisted suicide is accepted, so too must voluntary euthanasia be permitted. If assisted suicide is decriminalized and not voluntary euthanasia, the result may be an infringement of section 15, the equality provision in the *Charter*: those who are physically capable of committing assisted suicide would have the option to choose the time and manner of their death while those who are physically incapable of committing assisted suicide would not.

Some members feel that the common good could be endangered if the law is changed to accommodate the few cases where pain control is ineffective. They believe if there is clarification of withdrawing and withholding treatment, better training for personnel who work with those with irreversible illnesses, as well as improved management of pain relief and palliative care, most cases can be assuaged. These members, nevertheless, believe that while there are a small number of cases that cannot be dealt with adequately, these are not sufficient to justify legalizing euthanasia because it could create serious risks for the most vulnerable and threaten the fundamental value of life in society.

They also feel that there is a moral difference between euthanasia and the legitimate practices of withholding and withdrawing of life sustaining treatment and providing treatment aimed at alleviating suffering that may hasten death. In acts of euthanasia, the



*intention* is to cause death, whereas in other end of life decisions the *intention* is to alleviate suffering.

These members are sceptical as to the validity of opinion poll results often cited by those witnesses in favour of changes to the existing laws. They are concerned with the acceptance of such poll results at face value without close analysis of the questions asked, and the knowledge of the respondents with respect to the issues polled. Moreover, they have noted the confusion as to the terms used.

One member of the Committee, while favouring a change in the law with respect to assisted suicide, does not believe that the law regarding euthanasia should be changed. This member believes that Canadian society must move slowly on the issues of assisted suicide and euthanasia. A step by step approach is the more appropriate course of action. Assisted suicide is the first step because the principal agent of death is the dying person. Since that person has final control over the situation, there is an additional opportunity for that person to change his or her mind at the last minute. Voluntary euthanasia, on the other hand, should not be considered at this time since it may not be possible to design and put into place sufficient controls to prevent abuses.

While all these members oppose voluntary euthanasia and insist that it remain part of the *Criminal Code*, they believe the present penalties for this conduct are inappropriate where there is an essential element of compassion or mercy. Our law now makes voluntary euthanasia, like nonvoluntary euthanasia, first degree murder because the death in such cases is planned and deliberate. They believe that the mandatory life sentence for murder with no eligibility for parole for twenty-five years is too harsh in such cases and a less severe penalty should be provided. These members emphasize that this compassionate or merciful element must be clearly and narrowly defined in order to limit the availability of a more lenient sentence.

### *b) Views of Committee Members in Favour of Voluntary Euthanasia*

For these members, the equality argument under section 15 of the *Charter* is persuasive. If assisted suicide is permitted, as they believe it should be, voluntary euthanasia must also be accepted in order to avoid the unequal treatment of those who are physically incapable of committing assisted suicide.

Those in favour of changes believe the principle of autonomy that justifies allowing the withholding and withdrawing of life sustaining treatment also justifies permitting voluntary euthanasia. These members believe that the provision of treatment aimed at the alleviation of suffering that may hasten death is also similar to voluntary euthanasia. The death of the patient in all of these activities is a foreseeable consequence.

They believe that physicians who take the position that their role is to heal are excluding an important part of their function in society - to provide comfort and care to the ill. This latter role also includes the easing of suffering. For these members, euthanasia can be a merciful and appropriate response to suffering, in cases where it cannot be alleviated by other means.

## **Euthanasia**

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They believe the *Criminal Code* should be amended to permit voluntary euthanasia for competent individuals who are physically incapable of committing assisted suicide. The amendment should contain the same or similar safeguards as those recommended for assisted suicide. These members believe that the fact that the dying person requests death in voluntary euthanasia, unlike other forms of euthanasia, justifies permitting some form of legalization in such cases.

### *Involuntary Euthanasia*

The Committee believes that an act of terminating a person's life against his or her wishes is murder and should continue to be treated as such.

## **Recommendations**

### *Nonvoluntary Euthanasia*

**The Committee recommends nonvoluntary euthanasia remain a criminal offence.**

**The Committee recommends the *Criminal Code* be amended to provide for a less severe penalty in cases where there is the essential element of compassion or mercy. Parliament should consider the following options:**

- *A third category of murder could be created that would not carry a mandatory life sentence but rather would carry a less severe penalty; or*
- *A separate offence of compassionate homicide could be established that would carry a less severe penalty.*

**The essential elements of compassion and mercy must be clearly and narrowly defined in order to limit the cases in which a less stringent sentence would be available.**

**Parliament should determine the appropriate penalty.**

### *Voluntary Euthanasia*

**The majority recommends voluntary euthanasia remain a criminal offence. The *Criminal Code*, however, should be amended to allow for a less severe penalty similar to that provided for nonvoluntary euthanasia in cases where there is the essential element of compassion or mercy.**

**The minority recommends the *Criminal Code* be amended to permit voluntary euthanasia for competent individuals who are physically incapable of committing assisted suicide. This amendment would be subject to the same or similar minimum safeguards as outlined in the chapter on assisted suicide.**

The minority further recommends, that if voluntary euthanasia remains a criminal offence, the *Criminal Code* be amended to provide for a less severe penalty similar to the penalty for nonvoluntary euthanasia.

The Committee recommends research be undertaken into who is requesting euthanasia, why it is being requested, and whether there are any alternatives that might be acceptable to those who are making the requests.

### *Involuntary Euthanasia*

The Committee recommends that the prohibition against involuntary euthanasia continue under the present murder provisions in the *Criminal Code*.





## Conclusion

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**T**his study has covered the most important issues surrounding assisted suicide and euthanasia. There remain, however, issues regarding nonvoluntary euthanasia and end-of-life decisions, such as those involving persons in persistent vegetative states, neo-natal infants and other questions that require careful consideration

The Committee's deliberations were the result of careful analysis of opinions, of knowledge based on experience and beliefs grounded in personal morality and ethics compiled from witness statements and numerous briefs. The Committee's conclusions reflect consensus in many areas and differences on some of the most basic questions addressed. The members hope their Report will facilitate debate on the part of people and governments.

The Committee has endeavoured to respect and reflect Canadian societal views concerning the complex issues of assisted suicide and euthanasia. It believes that if the debate continues in an atmosphere of tolerance and empathy, the issues can be resolved in a manner that will respect and balance the fundamental right of individual choice with the common good of Canadian society.



## Appendix A

### Witnesses at Public Hearings

*All briefs received by the Committee have been deposited with the Library of Parliament. Comments about the report are welcome and may be sent by regular mail, by fax (613) 947-2104 or by E-Mail to [sencom@magi.com](mailto:sencom@magi.com)*

Witnesses	Issue no	Date
<b>Action Life</b> Ottawa, Ontario ✍ Carroll Rees, Executive Director ✍ Jonathan Bloedow, Member and Researcher	8	June 1, 1994
<b>AIDS Committee of Toronto</b> Toronto, Ontario ✍ Allan Stewart, Board Member ✍ Carole Yaworsky, Executive Director	12	July 5, 1994
<b>Alberta Indian Health Care Commission</b> Edmonton, Alberta ✍ Randy Bottle ✍ Richard Saunders	30	December 13, 1994
<b>Alberta Premier's Council on the Status of Persons with Disabilities</b> Edmonton, Alberta ✍ Gary McPherson, Chairman	18	September 30, 1994
<b>Alliance for Life</b> Winnipeg, Manitoba ✍ Anna Desilets, Executive Director ✍ Dr. Karel Gunning ✍ Patricia Soenen	17	September 29, 1994
<b>Alliance for Life (Ontario)</b> Guelph, Ontario ✍ Jakki Jeffs, Executive Director	8	June 1, 1994
<b>The Anglican Church of Ottawa</b> Ottawa, Ontario ✍ Rev. J.A. Baycroft	28	December 7, 1994
<b>Archdiocese of Vancouver</b> Vancouver, British Columbia ✍ Most Rev. Adam Exner, Archbishop of Vancouver ✍ Peter Ryan	15	September 27, 1994

## Witnesses at Public Hearings

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<b>Association des hôpitaux du Québec</b>		
Montreal, Quebec	19	October 5, 1994
✂ Dr. Paul Landry		
✂ Dr. Gilles Voyer		
✂ Me Pierre Bourbonnais		
<b>Association Québécoise de Soins Palliatifs</b>		
Montreal, Quebec	24	November 17, 1994
✂ Dr. Maurice Falardeau		
✂ Robert Dagenais		
<b>BC Association of Social Workers</b>		
Victoria, British Columbia	14	September 26, 1994
✂ Anne DuMoulin, Co-Chair		
✂ Michael Boyle, Co-Chair		
✂ Stuart Alcock, Executive Director		
<b>BC Civil Liberties Association</b>		
Vancouver, British Columbia	14	September 26, 1994
✂ John Westwood, Executive Director		
✂ Alister Browne, Board Member		
<b>BC Coalition of People With Disabilities</b>		
Vancouver, British Columbia	16	September 28, 1994
✂ Margo Massie, President		
✂ Mary Williams, External Vice President		
✂ Geoff McMurchy, Communications Officer		
<b>BC Coroner's Office</b>		
Burnaby, British Columbia	16	September 28, 1994
✂ Vince Cain, Chief Coroner		
✂ Dr. Sheila Carlisle, Forensic Pathologist		
<b>BC Hospice/Palliative Care Association</b>		
Cranbrook, British Columbia	16	September 28, 1994
✂ Shirley Coupal, President		
✂ Curtis Metzger, Vice President		
✂ Dr. David Kuhl, St. Paul's Hospital (Vancouver)		
<b>BC Persons with AIDS Society</b>		
Vancouver, British Columbia	16	September 28, 1994
✂ Arn Schilder, Chair		
✂ Pierre Beaulne, Advocacy and Communications Developer		
<b>David Boram</b>		
Vancouver, British Columbia	15	September 27, 1994
<b>John Boram</b>		
Vancouver, British Columbia	15	September 27, 1994
<b>Canadian AIDS Society</b>		
Ottawa, Ontario	12	July 5, 1994
✂ Russell Armstrong, National Programmes Director		
✂ Carole Neron		
✂ Steve Harris*		
✂ Terry Goodwin*		
<b>Canadian Association for Community Living</b>		
North York, Ontario	23	November 16, 1994
✂ Paulette Bertiaume, President		
✂ Diane Richler		
✂ John Bartram		



<b>Canadian Association for Suicide Prevention</b> Montreal, Quebec ✂ Dr. Brian L. Mishara, President	2	April 20, 1994
<b>Canadian Cancer Society</b> St. John's, Newfoundland ✂ Dr. Margaret Scott	6	May 18, 1994
<b>Canadian Conference of Catholic Bishops</b> Ottawa, Ontario ✂ Most Rev. Bertrand Blanchet, Archbishop of Rimouski ✂ Most Rev. Marcel Gervais, Archbishop of Ottawa ✂ Father Ron Mercier S.J., Regis College, Toronto	22	October 26, 1994
<b>Canadian Hospital Association</b> Ottawa, Ontario ✂ Carol Clemenhagen, President ✂ Mary Anne Bourque	19	October 5, 1994
<b>Canadian Medical Association</b> Ottawa, Ontario ✂ Dr. Bruno L'Heureux, President ✂ Dr. John Williams, Director, Department of Ethics ✂ Dr. Douglas Sawyer, Chair, Committee on Ethics ✂ Dr. Léo-Paul Landry, Secretary-General	25	November 23, 1994
<b>Canadian Nurses Association</b> Ottawa, Ontario ✂ Eleanor Ross, President ✂ Nora Hammell, Nursing Policy Consultant	19	October 5, 1994
<b>Canadian Palliative Care Association</b> Ottawa, Ontario ✂ Dr. Paul Henteleff, President ✂ Fay Struthers	5	May 11, 1994
<b>Canadian Pharmaceutical Association</b> Ottawa, Ontario ✂ Dr. Kevin Hall, President ✂ Leroy Favang, Executive Director	23	November 16, 1994
<b>Canadian Physicians for Life</b> Caledonia, Ontario ✂ Dr. Robert Pankratz, President ✂ Dr. Williard Johnston, Secretary-Treasurer ✂ Iain T. Benson, Legal Advisor ✂ Dr. Jim Lane	14	September 26, 1994
<b>The Canadian Unitarian Council</b> Surrey, British Columbia ✂ Brian J. Kiely, Chair, Death Decisions Committee ✂ Alison Harvey, Member	14	September 26, 1994
<b>Carrefour des Chrétiens du Québec pour la Santé</b> Montreal, Quebec ✂ Dr. Robert Filiatrault, President ✂ Jean François Malherbe, Chairman, Bioethics Committee	20	October 17, 1994
<b>Réjean Carrier</b> Quebec City, Quebec	3	April 27, 1994

## Witnesses at Public Hearings

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<b>Catholic Health Association of British Columbia</b>		
Vancouver, British Columbia	14	September 26, 1994
✍ Gerald J. Herkel, President		
✍ Susan House, Executive Director		
✍ Rev. John Horgan, Chairman, Ethics Committee		
<b>Catholic Health Association of Canada</b>		
Ottawa, Ontario	14	September 26, 1994
✍ Dr. Helen Hays		
✍ Elly Englefield		
✍ Bridget Campion		
✍ Gerry Hiebert		
<b>Catholic Health Association of Manitoba</b>		
Winnipeg, Manitoba	18	September 30, 1994
✍ Pat Murphy		
✍ Dr. Larry Reynolds		
<b>The Catholic Women's League of Canada</b>		
Winnipeg, Manitoba	17	September 29, 1994
✍ Claire Heron, National President		
✍ Heather Kolla, Past President		
✍ Dolores Fehr, Member		
<b>Centre for Excellence in HIV/AIDS</b>		
Vancouver, British Columbia	16	September 28, 1994
✍ Irene Goldstone, Director		
<b>Gerald Chipeur</b>		
Calgary, Alberta	27	November 30, 1994
<b>Choice in Dying, Ottawa</b>		
Nepean, Ontario	8	June 1, 1994
✍ Stanley Rosenbaum		
✍ Stella McMurrin		
<b>Christian Brethren</b>		
Winnipeg, Manitoba	18	September 30, 1994
✍ Don Logan		
✍ Norman Plater		
<b>Church of Sts. John and Paul</b>		
Fredericton, New Brunswick	24	November 17, 1994
✍ Rev. Kenneth Weir		
<b>Clinical Research Institute of Montreal</b>		
Montreal, Quebec	22	October 26, 1994
✍ Dr. David Roy, Director, Center for Bioethics		
<b>Clinical Research Institute of Montreal</b>		
Montreal, Quebec	22	October 26, 1994
✍ Dr. Neil Macdonald, Director, Cancer Ethics Programme		
<b>Dr. Howard Cohen</b>		
Ottawa, Ontario	26	November 24, 1994

<b>College of Family Physicians</b>		
Mississauga, Ontario	23	November 16, 1994
✍ Dr. Richard MacLachan, Chair of the Ethics Committee		
✍ Dr. Paul Rainsberry, Director of Education		
✍ Dr. Reg L. Perkins, Executive Director		
✍ Dr. Eugene Bereza, Member of the Ethics Committee		
<b>Community Hospice Association of Ontario</b>		
Don Mills, Ontario	10	June 15, 1994
✍ Heather M. Balfour, Executive Director		
✍ Mrs Duffy Davidson, Board Member		
<b>Compassionate Healthcare Network Association</b>		
Surrey, British Columbia	15	September 27, 1994
✍ Cheryl Eckstein, Founder and President		
✍ Dr. Michael Newton, Director		
✍ Dr. H. Robert C. Pankratz, Director		
<b>Conference of Mennonites in Canada</b>		
Winnipeg, Manitoba	18	September 30, 1994
✍ Helmut Harder, General Secretary		
✍ Doug Pritchard, Staff for Peace Justice and Social Concerns		
✍ Roma Quapp, Staff for the Resource Commission		
✍ Dr. Howard Zacharias, Regional Consultant in Geriatric Medicare		
✍ Tym Elias, Executive Secretary		
<b>Christopher Considine</b>		
Victoria, British Columbia	14	September 26, 1994
<b>Janine Corbeil</b>		
Montreal, Quebec	32	January 13, 1995
<b>Council of Canadians with Disabilities</b>		
Winnipeg, Manitoba	18	September 30, 1994
✍ Jim Derksen, Council Member		
✍ Paula Keirstead, Member of the Human Rights Committee		
✍ Allan Simpson, Past Chairman		
<b>Council on Aging</b>		
Ottawa, Ontario	32	January 13, 1995
✍ Miriam Chapman, Chair		
✍ Dr. Campbell Lamont, Member		
✍ Charles Scott		
<b>Julianne Cressman</b>		
Vancouver, British Columbia	16	September 28, 1994
<b>Department of Health</b>		
Ottawa, Ontario	29	December 12, 1994
✍ The Honourable Diane Marleau, P.C., Minister		
✍ André Juneau, Assistant Deputy Minister		
✍ Susan Lawson, Policy Analyst		
✍ Judy Ferguson, Director General		
<b>Department of Justice</b>		
Ottawa, Ontario	31	December 14, 1994
✍ The Honourable Allan Rock, P.C., Minister		

## Witnesses at Public Hearings

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<b>Dr. R.W. Dunn</b> White Rock, British Columbia	15	September 27, 1994
<b>Dying with Dignity</b> Toronto, Ontario ✍ Marilynn Seguin, Executive Director ✍ Martin Campbell, Barrister	7	May 25, 1994
<b>Evangelical Fellowship of Canada</b> Markham, Ontario ✍ Bruce Clemenger, Director of Public Affairs ✍ Janet Buckingham, Chair of Social Action Committee ✍ Stanley Grenz ✍ Dr. Edwin Hui ✍ Walter Lawrence	15	September 27, 1994
<b>Fédération québécoise des Centres d'hébergement et de soins de longue durée</b> Montreal, Quebec ✍ Claude Vézina ✍ Monique Coupal	32	January 13, 1995
<b>Focus on the Family</b> Vancouver, British Columbia ✍ Dr. Margaret Cottle	15	September 27, 1994
<b>Julie Foley</b> Ottawa, Ontario	4	May 4, 1994
<b>Goodbye: A Right to Die Society</b> Vancouver, British Columbia ✍ Charles Clapham, Director ✍ Darline Miller, Director	15	September 27, 1994
<b>Dr. James Gordon</b> Montreal, Quebec	27	November 30, 1994
<b>James Green</b> Vancouver, British Columbia	16	September 28, 1994
<b>George Griffith</b> Vancouver, British Columbia	16	September 28, 1994
<b>Health Law Institute</b> Halifax, Nova Scotia ✍ Dr. Robert Elgie, Director	20	October 17, 1994
<b>Henderson General Hospital</b> Hamilton, Ontario ✍ Dr. Elizabeth Latimer, Director of Palliative Care	4	May 4, 1994
<b>Hospice of All Saints</b> Ottawa, Ontario ✍ Barbara O'Connor, Executive Director ✍ Dr. Emily Geer, Medical Consultant	12	July 05, 1994
<b>Susan House</b> New Westminster, British Columbia	15	September 27, 1994
<b>Humanist Association of Ottawa</b> Ottawa, Ontario ✍ Trevor Banks, Member of Executive Committee	8	June 01, 1994



<b>Izaak Walton Killam Hospital</b> Halifax, Nova Scotia ✍ Dr. Nuala Kenny, Head, Department of Paediatrics	20	October 17, 1994
<b>Andrew Johnson</b> Vancouver, British Columbia	14	September 26, 1994
<b>Brian Kershaw*</b> Vancouver, British Columbia	15	September 27, 1994
<b>Hilda Krieg</b> Surrey, British Columbia	15	September 27, 1994
<b>Lubavitch Organization for Jewish Development</b> Vancouver, British Columbia ✍ Yoseph Thompson	14	September 26, 1994
<b>Paul Mackenzie</b> Winnipeg, Manitoba	18	September 30, 1994
<b>Maison Marc-Simon</b> Quebec, Quebec ✍ Dr. Michel Morissette ✍ Sister Agathe Côté	32	January 13, 1995
<b>Maison Michel Sarrazin</b> Sillery, Quebec ✍ Louis Dionne, Director General	13	July 6, 1994
<b>Manitoba Association for Rights and Liberties</b> Winnipeg, Manitoba ✍ Donald A. Bailey, President ✍ Tara Mullen, Program Co-ordinator ✍ Neil Searles	17	September 29, 1994
<b>Manitoba Cancer Treatment and Research Foundation</b> Winnipeg, Manitoba ✍ Dr. Harvey M. Chochinov, Head, Clinical Services and Academic Affairs	17	September 29, 1994
<b>Manitoba Hospice Foundation</b> Winnipeg, Manitoba ✍ Dr. Peter Kirk, Vice President ✍ Dr. Linda Kristjanson ✍ Dr. Deborah Dudgeon ✍ Fred Nelson	17	September 29, 1994
<b>Manitoba Physicians for Life</b> Winnipeg, Manitoba ✍ Dr. Paul V. Adams ✍ Dr. Nicole Caron-Boulet ✍ Dr. Harold Boey	18	September 30, 1994
<b>Janet McCaffrey</b> Winnipeg, Manitoba	17	September 29, 1994
<b>McGill University Centre for Medicine, Ethics and Law</b> Montreal, Quebec ✍ Edward Keyserlingk, Associate Professor Faculty of Medicine	1	March 15, 1994

## Witnesses at Public Hearings

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### **McGill University Centre for Medicine, Ethics and Law**

Montreal, Quebec 6 May 18, 1994  
 ✎ Margaret Somerville, Director

### **Linda Meyer**

Maple Ridge, British Columbia 14 September 26, 1994

### **Louise Normandin Miller**

Victoria, British Columbia 5 May 11, 1994

### **Cecilia Moore**

Vancouver, British Columbia 14 September 26, 1994

### **Ann Mullens**

Victoria, British Columbia 30 December 13, 1994

### **National Coalition of Concerned Mothers**

Burlington, Ontario 17 September 29, 1994  
 ✎ Lorna Dueck  
 ✎ Jean Echlin

### **Joanne Neubauer**

Victoria, British Columbia 15 September 27, 1994

### **New Brunswick Extra Mural Hospital Association**

Fredericton, New Brunswick 20 October 17, 1994  
 ✎ Dr. Gordon Fergusson

### **Niagara Community Impact Group**

Niagara, Ontario 31 December 14, 1994  
 ✎ Jake Janzen  
 ✎ Janice Buhr  
 ✎ Dr. Robert Buhr

### **Nova Scotia Palliative Care Association**

Sydney, Nova Scotia 23 November 16, 1994  
 ✎ Dr. Ina Cummings, Director  
 ✎ Judith Fuller

### **Sheila Noyes**

Thunder Bay, Ontario 18 September 30, 1994

### **Nurses for Life**

Ottawa, Ontario 8 June 1, 1994  
 ✎ Mary-Lynn McPherson  
 ✎ Diane Petrucka  
 ✎ Maureen Farnand

### **Russel Ogden**

New Westminster, British Columbia 14 September 26, 1994

### **Rev. John Oldham**

Winnipeg, Manitoba 18 September 30, 1994

### **Ontario Medical Association**

Toronto, Ontario 20 October 17, 1994  
 ✎ Dr. Michael Wyman, President  
 ✎ Dr. Ted Boadway, Director of Health Policy

### **Ontario Office of the Chief Coroner**

Toronto, Ontario 20 October 17, 1994  
 ✎ Dr. James Young, Chief Coroner  
 ✎ Dr. James Cairns, Deputy Chief Coroner

<b>Ontario Office of the Crown Attorney</b> Timmins, Ontario ✍ David Thomas	29	December 12, 1994
<b>Ontario Palliative Care Association</b> Owen Sound, Ontario ✍ Dr. James McGregor, Member of the Board ✍ Shari Douglas, President	4	May 04, 1994
<b>Rev. Bernard Osborg</b> Bridgetown, Nova Scotia	15	September 27, 1994
<b>Ottawa and District Physicians Who Respect Life</b> Ottawa, Ontario ✍ Dr. André Lafrance	7	May 25, 1994
<b>People in Equal Participation Inc.</b> Winnipeg, Manitoba ✍ Theresa Ducharme, Chair ✍ Sylvia Daniels	17	September 29, 1994
<b>Mark Pickup</b> Beaumont, Alberta	27	November 30, 1994
<b>Pro-Life Society of British Columbia</b> Kelowna, British Columbia ✍ Ted Gerk, President ✍ Betty Green, Director	15	September 27, 1994
<b>R.E.A.L. Women of British Columbia</b> Vancouver, British Columbia ✍ Cecilia von Dehn	15	September 27, 1994
<b>Responsable jusqu'à la fin</b> Quebec, Quebec ✍ Yvon Bureau, President	4	May 04, 1994
<b>The Right to Die Society of Canada</b> Victoria, British Columbia ✍ John Hofsess, Executive Director ✍ Gabrielle Gaspar, Member ✍ Dr. Markus Luckwaldt	25	November 23, 1994
<b>Right to Life Association of Toronto</b> Toronto, Ontario ✍ June Scandiffo, President ✍ Dr. Michael Berry	8	June 1, 1994
<b>Patricia Rodney</b> Vancouver, British Columbia	15	September 27, 1994
<b>R. Scott Rowand</b> Toronto, Ontario	9	June 8, 1994
<b>Royal College of Physicians and Surgeons of Canada</b> Ottawa, Ontario ✍ Dr. Gordon Crelinsten, Council Member ✍ Dr. Henry Dinsdale, President ✍ Dr. Pierre Paul Demers, Director	20	October 17, 1994
<b>Royal Victoria Hospital</b> Montreal, Quebec ✍ Dr. Balfour Mount, Director of Palliative Care	5	May 11, 1994

## Witnesses at Public Hearings

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<b>Royal Victoria Hospital</b> Montreal, Quebec ✍ Dr. Marcel Boisvert	6	May 18, 1994
<b>Elizabeth Semkiw</b> Winnipeg, Manitoba	18	September 30, 1994
<b>Thomas Sigurdson</b> Surrey, British Columbia	15	September 27, 1994
<b>Marcie Smordin</b> Vancouver, British Columbia	16	September 28, 1994
<b>St. Andrew's Presbyterian Church</b> Stratford, Ontario ✍ Rev. James Dickey	8	June 1, 1994
<b>Angèle St. Germain</b> Verdun, Quebec	9	June 8, 1994
<b>Sunnybrook Health Science Centre</b> Toronto, Ontario ✍ Dr. John Senn, Director of the Clinical Ethics Centre	9	June 8, 1994
<b>Thomas More Lawyers' Guild of Toronto</b> Toronto, Ontario ✍ Philip H. Horgan, President ✍ David Brown ✍ Angela Costigan ✍ Tim Egan	12	July 5, 1994
<b>Toronto Bayview Regional Cancer Centre</b> Toronto, Ontario ✍ Dr. Robert Buckman	26	November 24, 1994
<b>Toronto Hospital for Sick Children</b> Toronto, Ontario ✍ Dr. Abbyann Day Lynch, Director Bioethics Department	11	June 22, 1994
<b>United Church of Canada</b> Toronto, Ontario ✍ Ruth Evans, Director ✍ Rev. Ann L. Simmonds	27	November 30, 1994
<b>Université Laval</b> <b>Département des sciences infirmières</b> Ste. Foy, Quebec ✍ Danielle Blondeau	12	July 5, 1994
<b>University of Alberta</b> <b>Developmental Disabilities Centre</b> Edmonton, Alberta ✍ Richard Sobsey	18	September 30, 1994
<b>University of Calgary</b> <b>Department of Community Health Sciences</b> Calgary, Alberta ✍ Marja Verhoef	18	September 30, 1994
<b>University of Calgary</b> <b>Faculty of Medicine</b> Calgary, Alberta ✍ Dr. Douglas Kinsella	16	September 28, 1994



<b>University of Manitoba</b> <b>Centre for Applied Ethics</b> Winnipeg, Manitoba ✍ Arthur Schafer	18	September 30, 1994
<b>University of Manitoba</b> <b>Faculty of Law</b> Winnipeg, Manitoba ✍ Barney Sneiderman	6	May 18, 1994
<b>University of Sherbrooke</b> <b>Ethics Committee</b> Sherbrooke, Quebec ✍ Dr. Pauline Lesage-Jarjoura ✍ Dr. Suzanne Philips-Nootens ✍ Jean Desclos	29	December 12, 1994
<b>University of Toronto</b> <b>Faculty of Law</b> Toronto, Ontario ✍ Bernard Dickens	10	June 15, 1994
<b>University of Victoria</b> <b>Department of Philosophy</b> Victoria, British Columbia ✍ Dr. Eike-Henner W. Kluge	2	April 20, 1994
<b>Volunteer Home Support Group</b> Winnipeg, Manitoba ✍ Dennis Norbury, President ✍ Dr. Sandra Kirby, Vice President	17	September 29, 1994
<b>Dr. Harry van Bommel</b> Scarborough, Ontario	28	December 7, 1994
<b>Humphrey Waldock</b> West Vancouver, British Columbia	14	September 26, 1994
<b>Dr. Ken F. Walker (Dr. W.Gifford-Jones)</b> Toronto, Ontario	11	June 22, 1994
<b>Dr. Scott Wallace</b> Victoria, British Columbia	15	September 27, 1994

\*Indicates that witness appeared in camera

## **Witnesses at Public Hearings**

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**The following witnesses appeared via videoconference from Holland on October 25, 1994. A transcript of the meeting is contained in Issue No. 21 of the Proceedings of the Committee.**

**Dr. Dirkvan Bakker**

Surgeon, Member of Medical Ethical Committee for Patient Care, University Hospital  
Amsterdam, The Netherlands

**Dr. Elly De Heer**

General Practitioner, Professor at Erasmus University  
Rotterdam, The Netherlands

**Dr. Robert J.M. Dillman**

Secretary of Medical Affairs, Royal Dutch Medical Association  
Utrecht, The Netherlands

**Dr. A.P.M. Heintz**

Department of Obstetrics and Gynecology, University Hospital  
Utrecht, The Netherlands

**Mrs. Johanna Kits Nieuwenkamp**

Ministry of Health, Chair of the Committee on Bioethics of the Council of Europe  
Rijswijk, The Netherlands

**Dr. H.J.J. Leenen**

Professor of Social Medicine and Health Law, University of Amsterdam  
Amsterdam, The Netherlands

**Professor Johan Legemaate**

Counsellor, Royal Dutch Medical Association  
Utrecht, The Netherlands

**Professor Leo C.M. Meijers**

Attorney-General, Supreme Court of the Netherlands  
The Hague, The Netherlands

**Mr. Eugene Sutorius**

Attorney and Deputy Justice, Court of Appeal, Member of the Dutch Health Council  
Arnhem, The Netherlands

**Dr. J.J.M. Van Delden**

Sociologist and Medical Practitioner, Principal investigator for the R Emmelink Committee  
Utrecht, The Netherlands

**Dr. Gerrit van der Wal**

Inspector of Health in North-Holland  
Amsterdam, The Netherlands

**Mrs. Mary G. Vlaming**

Registered Nurse (retired)  
Amsterdam, The Netherlands

## Appendix B

### Written Submissions Received

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*The Committee received several thousand submissions from individuals and organizations. Some of these were short form letters or individual letters simply expressing an opinion for or against euthanasia and assisted suicide. Others were requests to appear, often accompanied by well-developed briefs, from organizations or private individuals. For reasons of time it was not possible to hear every group or individual who wrote to the Committee. The following is a list of the briefs received from organizations that did not appear as well as some of the more lengthy studies submitted by individuals. The Committee is grateful to all who took the time to express their views.*

**Abbotsford Right-to-Life Society**  
Abbotsford, British Columbia

**Alliance Action Inc.**  
Winnipeg, Manitoba

**Marie Achille**  
Burnaby, British Columbia

**Zoe Bernatksy**  
Willingdon, Alberta

**Lucille Birkett**  
Edmonton, Alberta

**R.E. Bowley**  
Peterborough, Ontario

**Calabogie, Renfrew Pro-Life Association**  
Calabogie, Ontario

**Canadian Association of Social Workers**  
Ottawa, Ontario

**Canadian Bar Association**  
Ottawa, Ontario

**Catholic Physicians Guild of Manitoba**  
Winnipeg, Manitoba

**Catholic Women's League of Canada**  
Various branches

**Centre for Renewal in Public Policy**  
Gloucester, Ontario

**Chevaliers de Colomb, Conseil provincial du Nouveau-Brunswick**  
Kedgewick, New Brunswick

**Chilliwack Pro Life Society**  
Chilliwack, British Columbia

**Christian Medical and Dental Society**  
Saskatoon, Saskatchewan

## **Written Submissions Received**

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**Christian Social Morals Action Committee**

Frankford, Ontario

**Susan Conrad**

Toronto, Ontario

**Corporation professionnelle des travailleurs sociaux du Québec**

Montreal, Quebec

**Council of Christian Reformed Churches in Canada**

Burlington, Ontario

**Pierre Coutlée**

Lasalle, Quebec

**Phyllis Creighton**

Toronto, Canada

**Ann Davis**

Nepean, Ontario

**Luc Déry**

Montreal, Quebec

**Janice Dillon**

Vancouver, British Columbia

**John Doyle**

Winnipeg, Manitoba

**Dunnville and Area Right to Life**

Dunnville, Ontario

**Betty Eckgren**

Victoria, British Columbia

**Dr. H.E. Emson**

Saskatoon, Saskatchewan

**Elly Englefield**

Sherwood Park, Alberta

**Audrey Floyd**

Surrey, British Columbia

**Rosalie Floyd**

Penticton, British Columbia

**La Fondation Lise T.**

Anjou, Quebec

**Brian Gifford**

Halifax, Nova Scotia

**Claude Girard**

Montreal, Quebec

**Christine Glazer**

Saskatoon, Saskatchewan

**David Golden**

Toronto, Ontario

**Antonio R. Gualtieri**

Ottawa, Ontario

**Dr. Sydney G. Grant**

Fredericton, New Brunswick

**Dr. Tadeusz Grygier**

Aylmer, Quebec





## Written Submissions Received

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**Vito Norejko**

London, Ontario

**Norwich United Church**

Norwich, Ontario

**J.V. O'Brien**

Baddeck, Nova Scotia

**Ottawa-Carleton Regional Palliative Care Association**

Ottawa, Ontario

**Physicians and Scientists for a Healthy World**

Nepean, Ontario

**Presbyterian Church of Canada**

Don Mills, Ontario

**The Providence Hospital**

Moose Jaw, Saskatchewan

**Pro-Vie Clare**

Church Point, Nova Scotia

**Thaddeus W. Pruss**

Surrey, British Columbia

**The Registered Nurses Association of British Columbia**

Vancouver, British Columbia

**Religious Hospitallers of St. Joseph**

Kingston, Ontario

**Religious Hospitallers of St. Joseph**

Windsor, Ontario

**Thaddée Renault**

Fredericton, New Brunswick

**Joan Renold**

White Rock, British Columbia

**Marc Richard**

St. John, New Brunswick

**Teresa Rojas**

Victoria, British Columbia

**Alex K.H. Rose**

Lacombe, Alberta

**Teresa Sasseville**

Ottawa, Ontario

**Izabela Schultz**

Vancouver, British Columbia

**Sisters of Charity of the Immaculate Conception**

Renforth, New Brunswick

**Sisters of Providence Continuing Care Centre**

Kingston, Ontario

**Sisters of St. Martha**

Antigonish, Nova Scotia

**Sisters of St. Martha**

Scarborough, Ontario

**Julianna Smith**

Mississauga, Ontario

**Les Soeurs de la Charité de Montréal**

Montreal, Quebec

**Dr. Jocelyne St-Arnaud**

Montreal, Quebec

**St. Joseph's College Catholic Bioethics Centre**

Edmonton, Alberta

**Strathaven Baptist Church**

Chatsworth, Ontario

**Rev. Dr. George Theckedath**

Ottawa, Ontario

**Toronto Catholic Doctors Guild**

Scarborough, Ontario

**Dr. Arnold Voth**

Edmonton, Alberta

**Attaleen Werner**

Willowdale, Ontario

**Gregor Wolbring**

Calgary, Alberta

**Women Alive**

Barrie, Ontario

**Women For Life, Faith and Family**

Abbotsford, British Columbia





## Appendix C

### Material Received by the Committee

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*In addition to the many briefs and letters, a number of books, articles, government publications, court decisions and unpublished documents were brought to the attention of the Special Committee.*

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## Appendix D

### Chronology of Major Canadian Developments and Events

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- 1972** Canadian Parliament abolished the offences of suicide and attempted suicide.
- November 1983** Under the direction of Dr. Nachum Gal (a pediatrician at the University of Alberta Hospital), nurse Barbara Howell injected a lethal dose of morphine into a severely brain-damaged infant who had been removed from life-support. Dr. Gal fled to Israel. The government of Alberta unsuccessfully sought the extradition from Israel of Dr. Gal to face murder charges. The Alberta Association of Registered Nurses suspended Barbara Howell for one year and her supervisor for four months.
- July 1983** The Law Reform Commission of Canada released its *Report on Euthanasia, Aiding Suicide and Cessation of Treatment*. This report recommended against legalizing or decriminalizing voluntary active euthanasia and aiding suicide. It also recommended that the *Criminal Code* be amended so as not to require a physician to undertake or continue to administer medical treatment where the treatment is against the wishes of the person or where the treatment has become therapeutically useless and is not in the best interests of the person. Finally, it recommended that the *Criminal Code* be amended so as not to prevent a physician from undertaking, or to oblige a physician to cease administering, appropriate palliative care intended to eliminate or to relieve the suffering of a person for the sole reason that such care is likely to shorten the life expectancy of that person.
- 1984** A Joint Statement on Terminal Illness was issued by the Canadian Nursing Association, the Canadian Medical Association, the Canadian Hospital Association in co-operation with the Canadian Bar Association and with advice from the Catholic Health Association of Canada and the Law Reform Commission. The statement established a procedure for Do Not Resuscitate (DNR) orders.
- June 1987** The Law Reform Commission of Canada released proposals for amending the *Criminal Code*. These included the recommendation that mercy killing be treated as second-degree murder rather than as first-degree. This second-degree murder would carry no fixed or minimum jail term. The proposals also included the recommendation that individuals who provide palliative care which shortens life should not be subject to penalty under the *Criminal Code*.

## **Chronology of Major Canadian Developments and Events**

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- 1989** The Report of the Subcommittee on Institutional Program Guidelines, Guidelines for Establishing Standards, Palliative-Care Services was released.
- 1990** In an interview, Dr. Perry (an NDP MLA) admitted to giving morphine injections to his father who was dying of cancer and admitted that these injections may have hastened his death. The B.C. College of Physicians and Surgeons stated that Dr. Perry simply provided his father with quality palliative care and did nothing wrong since treatment that may coincidentally hasten death is neither illegal or unethical.
- 1990** In *Malette v. Shulman*, the Ontario Court of Appeal upheld the right of a Jehovah's Witness to refuse life-saving blood transfusions and the principle that health care professionals have a duty to respect such a refusal. Further, it upheld the right to refuse (and the duty to respect the refusal of) such transfusions through an advance directive.
- July 4, 1990** In an interview with the Canadian Press, a Vancouver psychologist, David Lewis, publicly admitted to assisting personally in the suicides of eight persons with AIDS. An AIDS patient himself, Lewis later had an assisted death through an overdose of prescription drugs.
- 1991** Health and Welfare Canada and the Canadian Cancer Society released a report entitled "Cancer 2000" a national review of all aspects of cancer. This report made strong recommendations about the development of: regional palliative care centers; a compulsory curriculum for all health care professionals; a specialty in palliative care in both nursing and medicine; and divisions of palliative oncology in every regional cancer centre. It also called on the National Cancer Institute of Canada to end its neglect of the field of palliative care and to take a proactive stand toward palliative care research.
- March 27, 1991** Private Member's Bill C-351, An Act to amend the *Criminal Code* (terminally ill persons), was read for the first time in the House of Commons. The bill died on the Order Paper with the ending of the parliamentary session.
- May 16, 1991** Private Member's Bill C-203, An Act to amend the *Criminal Code* (terminally ill persons), was read for the first time in the House of Commons. On 24 September 1991 it received second reading and was referred to Legislative Committee H for consideration. The Committee began hearings on the bill on 29 October 1991. On 18 February 1992, the Legislative Committee H adjourned *sine die*.



**June 19, 1991**

Private Member's Bill C-261, An Act to legalize the administration of euthanasia under certain conditions, was read for the first time in the House of Commons. On 24 October 1991 it was debated at second reading and dropped from the Order paper.

**November 1991**

The B.C. Royal Commission on Health Care and Costs recommended that the provincial government lobby the federal government for changes to the *Criminal Code* such that the *Code* would recognize: the competent adult patient's right to refuse treatment or demand its cessation and that such a right may be exercised by a duly appointed proxy in cases where the patient is not competent; that terminally ill patients be allowed to request fatal doses of pain medication; s.241(b) of the *Criminal Code* be amended so that aiding the suicide of a terminally ill patient would not be a criminal offence; where consent of a patient is unavailable, the physician should not be under a legal obligation to provide therapeutically useless treatment nor should be criminally liable for the withdrawal of therapeutically useless treatment. To date, these recommendations have not been implemented.

**November 10, 1991**

The B.C. College of Physicians and Surgeons issued a statement against euthanasia after reviewing the deaths of two of Dr. Peter Graff's patients (both patients, one suffering from ALS and one suffering from colon cancer, died of repeated doses of morphine and valium). A provincial coroner's inquiry urged a review of Dr. Graff's actions by the College of Physicians and Surgeons. The College ruled that Dr. Graff's method of treatment was unacceptable and the coroner ruled that both patients died from morphine overdoses. However, no criminal charges were laid.

**January 6, 1992**

The Quebec Superior Court ruled in the case of Nancy B., a woman suffering from an incurable disease, that turning off her respirator at her request and letting nature take its course would not be a criminal offence.

**March 1992**

The Canadian Medical Association released a Policy Summary on Advance Directives for Resuscitation and other Life-Saving or Sustaining Measures. This Summary directed that physicians should assist their patients with these endeavours and they should honour a patient's advance directive unless there are reasonable grounds for not doing so.

**June 1992**

The Corporation Professionnelle des Médecins du Québec (CPMQ) admitted that it had reprimanded a physician after he had given a 38-year-old AIDS patient a lethal injection of potassium phosphate with the consent of the patient and his family. The CPMQ disciplined the physician with three months probation, he was ordered to consult with another doctor within 72 hours of taking on a new patient, and to consult with a colleague before administering large daily doses of morphine. No criminal charges were laid.

## Chronology of Major Canadian Developments and Events

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### August 1992

A Toronto nurse, Scott Mataya, entered a guilty plea to a lesser charge of administering a noxious substance. On 23 November 1991 he had been charged with first degree murder in the killing of a terminally ill patient at the Wellesley Hospital. The patient had consented to the withdrawal of his ventilator so that death could occur. The patient began to convulse and vomit and Mataya gave him a lethal dose of potassium chloride. Mataya was convicted and received the maximum three-year probation period, a suspended sentence and was ordered to surrender his nursing licence.

### November 1992

The Sub-Committee of the Standing Committee on Justice and the Solicitor General on the Recodification of the General Part of the *Criminal Code* heard witnesses on the implications of the *Criminal Code* for health care providers who give effect to the directions of patients to withdraw medical treatment and on the question of physician-assisted suicide.

### December 9, 1992

Private Member's Bill C-385, An Act to amend the *Criminal Code* (aiding suicide) was read for the first time in the House of Commons. This bill was never debated in Parliament and died on the Order Paper when an election was called.

### 1993

The Canadian Medical Association released *Canadian Physicians and Euthanasia*. This Report was intended to provide information to physicians so that they might develop their own position on the topic.

### 1993

Vancouver newspaper columnist Lyn Cockburn and two of her senior editors were found in contempt of court when they refused to give a coroner's inquest the identity of their source for a 1991 article describing the assisted suicide of a woman with AIDS. The coroner's decision has been referred to judicial review by the British Columbia Supreme Court.

### February 1993

The Sub-Committee on the Recodification of the General Part of the *Criminal Code* of the Standing Committee on Justice and the Solicitor General recommended that the Minister of Justice conduct a review of the legal and philosophical issues surrounding assisted suicide.

### March 22, 1993

Members of the House of Commons defeated a motion that called upon the government to consider the advisability of introducing legislation on the subject of euthanasia and ensuring that those assisting terminally ill persons who wish to die will not be subject to criminal liability.

### April 1993

An Ontario physician who gave a lethal injection to a seriously ill cancer patient was given a three-year suspended sentence after

pleading guilty to a charge of administering a noxious substance. The physician had been charged with second-degree murder.

**September 30, 1993**

In a five to four decision, the Supreme Court of Canada dismissed an appeal by Sue Rodriguez (a woman suffering from the incurable disease of amyotrophic lateral sclerosis) in which she challenged the validity of the *Criminal Code* prohibition on assisted suicide under the *Canadian Charter of Rights and Freedoms*. On 29 December 1992 the British Columbia Supreme Court had ruled that section 241 of the *Criminal Code* does not violate the *Canadian Charter of Rights and Freedoms*. On 8 March 1993, in a 2 to 1 decision, the British Columbia Court of Appeal had dismissed an appeal by Sue Rodriguez with respect to her request for physician-assisted suicide.

**November 3, 1993**

The British Columbia Ministry of the Attorney General issued Crown Counsel Guidelines on Euthanasia and Assisted Suicide.

**February 16, 1994**

Private Members' Bill C-215 was read for the first time in the House of Commons

**August 1994**

The Canadian Medical Association voted against euthanasia.

**September 1994**

A Joint Statement on Advance Directives was released by the Canadian Long Term Care Association, the Canadian Home Care Association, the Canadian Hospital Association, the Canadian Nurses Association, the Canadian Public Health Association, and Home Support Canada (developed in collaboration with the Canadian Bar Association). This statement includes guiding principles for health care facilities when developing cardiopulmonary-resuscitation (CPR) policy, CPR as a treatment option, competence, the treatment decision, its communication, implementation and review, and palliative care and other treatment.

**October 1994**

A Joint Statement on Resuscitative Interventions was released by the Canadian Hospital Association, the Canadian Medical Association, and the Catholic Health Association of Canada (developed in cooperation with the Canadian Bar Association).

**November 1994**

Robert Latimer was given the mandatory minimum sentence of life imprisonment with no possibility of parole for ten years for the second-degree murder of his daughter Tracy. Tracy had been born with a severe form of cerebral palsy and was severely physically and developmentally disabled. In order to end her suffering, Mr. Latimer put Tracy in the cab of his truck and piped the exhaust back into the cab. Tracy died of carbon monoxide poisoning.

**December 1994**

A Halifax couple, Cheryl May Myers and Michael William Power, were given suspended sentences, three years' probation, and 150

hours of community service after they pled guilty to manslaughter for suffocating Ms. Myers' terminally ill father. The pair had been charged with second-degree murder.

**February 1995**

Jean Brush pleads guilty to manslaughter in the death of her husband who was suffering from Alzheimer's. Cecil Brush had expressed his wish to die in July 1994. The judge felt that she had suffered enough and he gave her a non-custodial sentence.

This Chronology draws heavily on: Margaret Smith and Susan Alter (Law and Government Division) and Sandra Harder (Political and Social Affairs Division), "Current Issue Review 91-9E, Euthanasia and Cessation of Treatment," Research Branch, Library of Parliament (6 February 1992, Revised 12 January 1994); and Russel Ogden, "The Right to Die: A Policy Proposal for Euthanasia and Aid in Dying," *Canadian Public Policy* 20:1 (1994) 1-25. Other information was distilled from testimony.

## Appendix E

### Legislative Proposals Previously Introduced in Parliament

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*A number of Private Members' Bill have been introduced in the House of Commons in relation to euthanasia or assisted suicide. These include*

*Bill C-351 (Mr. Robert Wenman)*

*Bill C-203 (Mr. Robert Wenman)*

*Bill C-261 (Mr. Chris Axworthy)*

*Bill C-385 (Mr. Svend Robinson)*

*Bill C-215 (Mr. Svend Robinson).*

#### C-215

Mr. Robinson (Burnaby- Kingsway)

*An Act to amend the Criminal Code (aiding suicide)*

Introduced and read for the first time - February 16, 1994

Placed on the Order of Precedence - February 22, 1994

Debated at second reading; dropped from the Order Paper - September 21, 1994

#### C-385

Mr. Robinson (Burnaby- Kingsway)

*An Act to amend the Criminal Code (aiding suicide)*

Introduced and read for the first time - December 9, 1992

Prorogation of Parliament

#### C-261

Mr. Axworthy (Saskatoon- Clark's Crossing)

*An Act to legalize the administration of euthanasia under certain conditions to persons who request it and who are suffering from an irremedial condition and respecting the withholding and cessation of treatment and to amend the Criminal Code*

Introduced and read for the first time - June 19, 1991

Placed on the Order of Precedence - September 24, 1991

Debated at second reading; dropped from the Order Paper - October 24, 1991



## Legislative Proposals Previously Introduced in Parliament

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**C-203**

Mr. Wenman - *An Act to amend the Criminal Code* (terminally ill persons)  
Introduced and read for the first time - May 16, 1991  
Placed on the Order of Precedence - May 16, 1991  
Designated as a votable item - May 31, 1991  
Debated at second reading; read the second time and referred to Legislative Committee H - September 24, 1991

**C-351**

Mr. Wenman - *An Act to amend the Criminal Code* (terminally ill persons)  
Introduced and read for the first time - March 27, 1991  
Prorogation of Parliament

## Appendix F

### Relevant Provisions of the *Criminal Code* and the *Civil Code*

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#### Criminal Code

*The subject areas that were identified as being dealt with, directly or indirectly, in the Code are: (1) pain control and sedation practices (2) withholding and withdrawal of life-sustaining treatment, (3) assisted suicide, and (4) euthanasia. Furthermore, although certain portions of the provisions may not appear to relate directly to the conduct described, the sections have not, for the most part, been abridged in light of the fact that each provision should be read in its entirety in order to better appreciate its purpose.*

#### Consent to Death

14. No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

#### Surgical Operations

45. Every one is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person if

- (a) the operation is performed with reasonable care and skill; and
- (b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

#### Duty of Persons to Provide Necessaries

215. (1) Every one is under a legal duty

- (a) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;
- (b) as a married person, to provide necessaries of life to his spouse; and
- (c) to provide necessaries of life to a person under his charge if that person
  - (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
  - (ii) is unable to provide himself with the necessaries of life.

(2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies upon him, to perform that duty, if

(a) with respect to a duty imposed by paragraph (1)(a) or (b),

(i) the person to whom the duty is owed is in destitute or necessitous circumstances, or

(ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or

(b) with respect to a duty imposed by paragraph 1(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

(3) Every one who commits an offence under subsection (2) is guilty of

(a) an indictable offence and is liable to imprisonment for a term not exceeding two years; or

(b) an offence punishable on summary conviction.

### **Duty of Persons Undertaking Acts Dangerous to Life**

**216.** Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in doing so.

### **Duty of Persons Undertaking Acts**

**217.** Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life.

### **Criminal Negligence**

**219. (1)** Every one is criminally negligent who

(a) in doing anything, or

(b) omitting to do anything that it is his duty to do,

shows wanton or reckless disregard for the lives or safety of other persons.

(2) For the purposes of this section, “duty” means a duty imposed by law.

### **Causing Death by Criminal Negligence**

**220.** Every one who by criminal negligence causes death to another person is guilty of an indictable offence and is liable to imprisonment for life.

### **Causing Bodily Harm by Criminal Negligence**

**221.** Every one who by criminal negligence causes bodily harm to another person is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

### **Homicide**

**222. (1)** A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.

(2) Homicide is culpable or not culpable.

- (3) Homicide that is not culpable is not an offence.
- (4) Culpable homicide is murder or manslaughter or infanticide.
- (5) A person commits culpable homicide when he causes the death of a human being,
  - (a) by means of an unlawful act,
  - (b) by criminal negligence,
  - (c) by causing that human being, by threats or fear of violence or by deception, to do anything that causes his death, or
  - (d) by wilfully frightening that human being, in the case of a child or sick person.

## **Murder**

### **229. Culpable homicide is murder**

- (a) where the person who causes the death of a human being
  - (i) means to cause his death, or
  - (ii) means to cause him bodily harm that he knows is likely to cause his death, and is reckless whether death ensues or not;
- (b) where a person, meaning to cause death to a human being or meaning to cause him bodily harm that he knows is likely to cause his death, and being reckless whether death ensues or not, by accident or mistake causes death to another human being, notwithstanding that he does not mean to cause death or bodily harm to that human being; or
- (c) where a person, for an unlawful object, does anything that he knows or ought to know is likely to cause death, and thereby causes death to a human being, notwithstanding that he desires to effect his object without causing death or bodily harm to any human being.

## **Classification of Murder**

- 231. (1) Murder is first degree murder or second degree murder.
- (2) Murder is first degree murder when it is planned and deliberate.
- ...
- (7) All murder that is not first degree murder is second degree murder.

## **Manslaughter**

- 234. Culpable homicide that is not murder or infanticide is manslaughter.

## **Punishment for Murder**

- 235. (1) Every one who commits first degree murder or second degree murder is guilty of an indictable offence and shall be sentenced to imprisonment for life.
- (2) For the purposes of Part XXIII [*Punishments*], the sentence of imprisonment for life prescribed by this section is a minimum punishment.

## **Punishment for Manslaughter**

**236.** Every one who commits manslaughter is guilty of an indictable offence and liable to imprisonment for life.

## **Counselling or Aiding Suicide**

**241.** Every one who

- (a) counsels a person to commit suicide, or
- (b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

## **Administering Noxious Thing**

**245.** Every one who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence and liable

- (a) to imprisonment for a term not exceeding fourteen years, if he intends thereby to endanger the life of or to cause bodily harm to that person; or
- (b) to imprisonment for a term not exceeding two years, if he intends thereby to aggrieve or annoy that person.

## **Assault**

**265. (1)** A person commits an assault when

- (a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly;
- (b) he attempts or threatens, by an act or a gesture, to apply force to another person, if he has, or causes that other person to believe upon reasonable grounds that he has, present ability to effect his purpose; or

...

(2) This section applies to all forms of assault, including sexual assault, sexual assault with a weapon, threats to a third party or causing bodily harm and aggravated sexual assault.

(3) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of

- (a) the application of force to the complainant or to a person other than the complainant;
- (b) threats or fear of the application of force to the complainant or to a person other than the complainant;
- (c) fraud; or
- (d) the exercise of authority.

(4) Where an accused alleges that he believed that the complainant consented to the conduct that is the subject-matter of the charge, a judge, if satisfied that there is sufficient evidence and that, if believed by the jury, the evidence would constitute a defence, shall instruct the jury, when reviewing all the evidence relating to the determination of the honesty of the accused's belief, to consider the presence or absence of reasonable grounds for that belief.



**266.** Every one who commits an assault is guilty of

- (a) an indictable offence and liable to imprisonment for a term not exceeding five years, or
- (b) an offence punishable on summary conviction.

### **Assault Causing Bodily Harm**

**267.** (1) Every one who, in committing an assault,

...

- (b) causes bodily harm to the complainant,

is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

(2) For the purposes of this section and sections 269 and 272, “bodily harm” means any hurt or injury to the complainant that interferes with the health or comfort of the complainant and that is more than merely transient or trifling in nature.

### **Aggravated Assault**

**268.** (1) Every one commits an aggravated assault who wounds, maims, disfigures or endangers the life of the complainant.

(2) Every one who commits an aggravated assault is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

### **Unlawfully Causing Bodily Harm**

**269.** Every one who unlawfully causes bodily harm to any person is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

### **Sentence of Life Imprisonment**

**742.** Subject to s.742.1 [*Power of court to delay parole*], the sentence to be pronounced against a person who is to be sentenced to imprisonment for life shall be

(a) in respect of a person who has been convicted of high treason or first degree murder, that he be sentenced to imprisonment for life without eligibility for parole until he has served twenty-five years of his sentence;

(a.1) in respect of a person who has been convicted of second degree murder where that person has previously been convicted of culpable homicide that is murder, however described under this Act, that he be sentenced to imprisonment for life without eligibility for parole until he has served twenty-five years of his sentence;

(b) in respect of a person who has been convicted of second degree murder, that he be sentenced to imprisonment for life without eligibility for parole until he has served at least ten years of his sentence or such greater number of years, not being more than twenty-five years, as has been substituted therefore pursuant to section 744; and

(c) in respect of a person who has been convicted of any other offence, that he be sentenced to imprisonment for life with normal eligibility for parole.

## **Civil Code**

### **Title Two Certain Personality Rights**

#### **Chapter I Integrity Of The Person**

**Art. 10** Every person is inviolable and is entitled to the integrity of his person.

Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent.

#### **Section I Care**

**Art. 11** No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent.

If the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place.

**Art. 12** A person who gives his consent to or refuses care for another person is bound to act in the sole interest of that person, taking into account, as far as possible, any wishes the latter may have expressed.

If he gives his consent, he shall ensure that the care is beneficial notwithstanding the gravity and permanence of certain of its effects, that it is advisable in the circumstances and that the risks incurred are not disproportionate to the anticipated benefit.

**Art. 13** Consent to medical care is not required in case of emergency if the life of the person is in danger or his integrity is threatened and his consent cannot be obtained in due time.

It is required, however, where the care is unusual or has become useless or where its consequences could be intolerable for the person.

**Art. 14** Consent to care required by the state of health of a minor is given by the person having parental authority or by his tutor.

A minor fourteen years of age or over, however, may give his consent alone to such care. If his state requires that he remain in a health or social services establishment for over twelve hours, the person having parental authority or tutor shall be informed of that fact.

**Art. 15** Where it is ascertained that a person of full age is incapable of giving his consent to care required by his state of health, consent is given by his mandatary, tutor or curator. If the person of full age is not so represented, consent is given by his spouse or, if he has no spouse or his spouse is prevented from giving consent, it is given by a close relative or a person who shows a special interest in the person of full age.

**Art. 16** The authorization of the courts is necessary where the person who may give consent to care required by the state of health of a minor or a person of full age who is incapable of giving his consent is prevented from doing so or, without justification, refuses to do so; it is also required where a person of full age who is incapable of giving his consent categorically refuses to receive care, except in the case of hygienic care or emergency.

The authorization of the court is necessary, furthermore, to cause a minor fourteen years of age or over to undergo care he refuses, except in the case of emergency if his life is in danger or his integrity threatened, in which case the consent of the person having parental authority or the tutor is sufficient.

**Art. 17** A minor fourteen years of age or over may give his consent alone to care not required by the state of his health; however, the consent of the person having parental authority or of the tutor is required if the care entails a serious risk for the health of the minor and may cause him grave and permanent effects.

**Art. 18** Where the person is under fourteen years of age or is incapable of giving his consent, consent to care is not required by his state of health is given by the person having parental authority or the mandatary, tutor or curator; the authorization of the court is also necessary if the care entails a serious risk for health or if it might cause grave and permanent effects.

**Art. 19** A person of full age who is capable of giving his consent may alienate a part of his body *inter vivos*, provided the risk incurred is not disproportionate to the benefit that may reasonably be anticipated.

A minor or a person of full age who is incapable of giving his consent may, with the consent of the person having parental authority, mandatary, tutor or curator and with the authorization of the court, alienate a part of his body only if that part is capable of regeneration and provided that no serious risk to his health results.

**Art. 20** A person of full age who is capable of giving his consent may submit to an experiment provided that the risk incurred is not disproportionate to the benefit that can reasonably be anticipated.

**Art. 21** A minor or a person of full age who is incapable of giving his consent may be submitted to an experiment only in the absence of serious risk to his health and of objection on his part, provided that he understands the nature and consequences of the act; the consent of the person having parental authority or of the mandatary, tutor or curator is necessary.

An experiment may be carried out on one person alone only if a benefit to the health of that person may be expected, and the authorization of the court is necessary.

An experiment on a group of minor persons or incapable persons of full age shall be carried out within the framework of a research project approved by the Minister of Health and Social Services, upon the advice of an ethics committee of the hospital designated by the Minister or of an ethics committee created by him for that purpose; in addition, such an experiment may be carried out only if a benefit to the health of persons of the same age group and having the same illness or handicap as the persons submitted to the experiment may be expected.

Care considered by the ethics committee of the hospital concerned to be innovative care required by the state of health of the person submitted to it is not an experiment.

**Art. 22** A part of the body, whether an organ, tissue, or other substance, removed from a person as part of the care he receives may, with his consent or that of the person qualified to give consent for him, be used for purposes of research.

**Art. 23** When the court is called upon to rule on an application for authorization with respect to care, the alienation of a part of the body, or an experiment, it obtains the opinions of experts, of the person having the parental authority, of the mandatary, of the tutor or the curator and of the tutorship council; it may also obtain the opinion of any person who shows a special interest in the person concerned by the application.

The court is also bound to obtain the opinion of the person concerned unless that is impossible, and to respect his refusal unless the care is required by his state of health.

**Art. 24** Consent to care not required by a person's state of health, to the alienation of a part of a person's body, or to an experiment shall be given in writing.

It may be withdrawn at any time, even verbally.

**Art. 25** The alienation by a person of a part or product of his body shall be gratuitous; it may not be repeated if it involves a risk to his health.

An experiment may not give rise to any financial reward other than the payment of an indemnity as compensation for the loss and inconvenient suffered.

## Appendix G

### Sample Amendment Proposals

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*During the course of its study the Committee received a number of proposals for amendments to the Criminal Code.*

#### **1. Prof. Bernard M. Dickens (Excerpt from brief presented to the Special Committee)**

1. Assisted suicide should be accommodated under the *Criminal Code* by the introduction of an exception to section 241(b). Counselling should remain punishable under section 241(a).

2. A person physically incapable of suicide should be able to apply to a court under comparable guidelines to those proposed by Chief Justice Lamer in the *Rodriguez* case in order to be permitted to die with the assistance of another. This would require an exception to section 14 of the *Criminal Code*, which provides as follows:

14. No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

3. The presiding judge, in each case, would give a specified person a discretion, as opposed to a duty, to act; that is, the applicant would have no “right-to-die”, and the specified person would have no “duty to kill”.

4. The condemnation of killing without or outside the scope of judicial approval, as described in paragraph 2 above, would be practically reinforced by introduction of a more sensitive category of indictable third degree murder for which the punishment, like that for manslaughter and criminal negligence causing death, would be up to life imprisonment. The judge would cater the punishment on conviction to the evidence of the circumstances. A person charged with first or second degree murder could be convicted of third degree murder on evidence that establishes a killing following the victim’s competent request made outside a judicial approval. Killing, without the grant of a request, would remain punishable probably as first degree murder. A category of third degree murder might better preserve the balance than existing law between the public’s assurance of the protection of vulnerable human life and the recognition of non-malicious but misguided infliction of death.



#### **2. Eike-Henner Kluge, Proceedings, September 27, 1994, Issue no. 15, pp. 39-43.**

“I would therefore suggest to this Committee that a possible restructuring of the *Criminal Code* in this matter might proceed as follows:

217.1 Nothing in sections 14, 45, 215, 216 and 217 and other relevant sections of the *Criminal Code* shall be interpreted as



(a) requiring a qualified medical practitioner to commence or continue to administer surgical or medical treatment to a person who competently requests that such treatment not be commenced or continued;

(b) requiring a qualified medical practitioner to commence or continue to administer surgical or medical treatment to a person who has previously made a competent determination that such treatment not be commenced or continued and who has not revoked such determination;

(c) requiring a qualified medical practitioner to commence or continue to administer surgical or medical treatment to a person when a duly empowered proxy decision-maker of that person, using appropriate standards of proxy decision-making, formally requests that such treatment not be commenced or continued; or

(d) preventing a qualified medical practitioner from commencing or continuing to administer palliative care and measures intended to eliminate or relieve the suffering of a person for the sole reason that such care or measures will or are likely to shorten the life expectancy of the person, except where

(i) that person competently requests or has competently requested that such measures not be undertaken if these measures have a life shortening effect; or

(ii) the duly empowered proxy decision-maker of that person, using appropriate standards of proxy decision-making, requests that such measure not be undertaken if these measures have a life shortening effect.

“I would further recommend that this Committee accept in its wisdom that several new sections be added to the *Criminal Code*, to read as follows:”

xxx.1 Notwithstanding anything in section 14, 45, 215, 216, 217 or any other relevant section, no qualified medical practitioner commits an offence set out in those sections where the practitioner

(a) does not commence or continue to administer

(i) surgical or medical treatment to a person who competently and formally requests that such treatment not be commenced or continued;

(ii) surgical or medical treatment to a person who has previously made a competent determination that such treatment not be commenced or continued and who has not revoked such determination;

(iii) surgical or medical treatment to a person when a duly empowered proxy decision-maker of that person, using appropriate standards of proxy decision-making, formally requests that such treatment not be commenced or continued;

or

(b) commences or continues to administer palliative care and measures intended to eliminate or relieve the suffering of a person for the sole reason that such care or measures will or are likely to shorten the life expectancy of the person, except where

(i) that person competently requests or has competently requested that such measures not be undertaken if these measures have such a life shortening effect, or

(ii) the duly empowered proxy decision-maker of that person, using appropriate standards of proxy decision-making, requests that such measure not be undertaken if these measures have a life shortening effect.

xxx.2 In the event that the life of the person will or is likely to be shortened by the use of palliative measures involving medications or similar means, and the time-span of this shortening exceeds what would normally be expected using appropriate and recognized palliative measures, the case shall be subject to review by an independent body consisting of a

physician having no connection with any party involved in the case, a member of the Attorney General's Department of the jurisdiction in which the death has occurred, and an independent member of the public having training in ethics.

xxx.3 If this independent body finds that the event was not in accordance with the competently expressed wishes of the patient or in accordance with appropriate standards of proxy decision-making, as the case may be, the otherwise relevant provisions of the *Criminal Code* shall apply.

Further, since the Supreme Court agreed, in unanimous fashion, that Section 241(b) of the *Criminal Code* violates Section 15 of the *Charter of Rights*, since the proposals by Chief Justice Lamer of the Supreme Court of Canada and Chief Justice McEachern of the British Columbia Court of Appeals, each in their own fashion, would meet the requirements set out in Section 1 of the *Charter* I would urge this Committee to agree that Section 241(b) of the *Criminal Code* should be struck down as not being saved by Section 1 itself.

Further, I would urge this Committee to consider the following as a draft proposal for a voluntary euthanasia statute:

yyy.1 If a person suffers from an incurable and irremediable disease or medical condition, and if that person experiences the disease or condition as violating the fundamental values of that person, then

(a) that person may make application to a superior court for permission to request the assistance of a physician in terminating his life as quickly and as painlessly as possible in keeping with the fundamental values of that person; and

(b) on presentation of evidence by an independent psychiatrist and the attending physician that the person making the request is competent to do so, the court shall hear such a request as expeditiously as possible.

yyy.2 The court, upon due consideration of the mental physical state of the person requesting permission under yyy.1, and of that person's fundamental values; and taking due account of the medical nature of the affliction of the person requesting such assistance, may grant such an application.

yyy.3 Any permission granted under sec.yyy.2

(a) shall be registered with the regional coroner of the relevant jurisdiction;

(b) shall be for a period of six months; and

(c) shall include an order that there shall be due notification of the coroner if such a permission has been acted upon.

yyy.4 Any physician acting upon a permission granted under sec. yyy.2 an in accordance with the wishes of the person making the request under yyy.1, shall use such measures as he deems, upon due consideration, to be appropriate for terminating the life of that person as quickly and painlessly as possible.

yyy.5 Any physician acting upon a permission granted under secs. yyy.2, yyy.3 and yyy.4, and acting in accordance with the provisions set out therein, shall be deemed not to have committed an offence within the meaning of this Act.

zzz.1 Any person who suffers from an incurable and irremediable disease or medical condition, and who, by reason of incompetence, is unable to make application to a court as allowed under sec. yyy.1, may have such application made for him by a duly empowered proxy decision-maker using appropriate standards of proxy decision-making.

zzz.2 Any application brought under sec. zzz.1 shall be treated by the court as though it was an application brought by the incompetent person on his own behalf.

zzz.3 In considering an application brought under sec. zzz.1, the court shall have due regard to the previous competently expressed wishes and values of the now incompetent person, if that person was previously competent.

zzz.4 In the event that such values cannot be satisfactorily ascertained, the court shall use the values and standards currently accepted by Canadian society, where the nature of these values and standards shall be determined by the court in consultation with

- (a) a duly empowered representative of an association for handicapped persons;
- (b) a practising physician;
- (c) a practising nurse;
- (d) a person having expertise in biomedical ethics; and
- (e) a member of the public at large.

zzz.5 In the event that an application brought under sec. zzz.1 is on behalf of a person who has never been competent, the court shall use the values and standards currently accepted by society, where these values shall be determined as under sec. zzz.4.



### **3. Law Reform Commission, Euthanasia, aiding suicide, and cessation of treatment, Report 20, July, 1983.**

#### **1. Euthanasia**

The Commission does not favour the legalization of euthanasia in any form. That is the view expressed in the following two recommendations, both discussed earlier in the Report:

**The Commission recommends against legalizing or decriminalizing voluntary active euthanasia in any form and is in favour of continuing to treat it as culpable homicide.**

**The Commission recommends that mercy killing not be made an offence separate from homicide and that there be no formal provision for special modes of sentencing for this type of homicide other than what is already provided for homicide.**

#### **II. Aiding Suicide**

The Commission does not favour decriminalizing the offence of aiding or counselling suicide. In Working Paper No. 28 it tentatively recommended that, “[n]o person shall be prosecuted for an offence under the present section without the personal written authorization of the Attorney General”. However, in this Report, for reasons explained earlier, the Commission has omitted that particular recommendation. On the subject of aiding or counselling suicide, the following recommendation expresses the Commission’s final position:

**The Commission recommends that aiding suicide not be decriminalized, and that section 224\* of the *Criminal Code* be retained in its present form.**

### III. Cessation and Refusal of Treatment

The Commission recommends the following amendments to the *Criminal Code*:

**199.1 Nothing in sections 14, 45, 198, 199 and 229 shall be interpreted as requiring a physician**

**(a) to continue to administer or to undertake medical treatment against the expressed wishes of the person for whom such treatment is intended;**

**(b) to continue to administer or undertake medical treatment, when such treatment has become therapeutically useless in the circumstances and is not in the best interests of the person for whom it is intended.**

This provision is essentially similar to what the Commission proposed in Working Paper 28. The few changes which have been made merit brief commentary.

The addition of section 229 to the proposed section was made at the suggestion of one of the legal groups consulted. Section 229 of the *Criminal Code* creates the offence of administering noxious things or poison to someone. Although it is highly unlikely that this provision would be applied in medical matters, it was thought advisable to include it since it is at least potentially applicable.

The adverb “clearly” has been removed from both paragraphs of the proposed provision. In the Working Paper both paragraphs referred to, “...the clearly expressed wishes...”. Representatives of one of the provincial Bars convinced us that this word did not actually add anything and threatened to create difficulties in interpretation. Accordingly, we have omitted it from the final version.

Many of our correspondents criticized the use of the expression, “medically useless treatment”, in the amendment proposed by the Working Paper. It was suggested that this expression has an excessively pejorative connotation used in this context. In that it implies that the general practice in medicine is to provide extraordinary treatment, or to “overtreat”.

A treatment which is initially medically useful may become useless at a certain later point from the therapeutic perspective. To better express the idea that treatment is a continuum and to underline the notion that at a certain point in time the same treatment can become useless in terms of curing or improving the patient’s condition, we changed the expression “medically useless treatment”, to, “treatment [that] has become therapeutically useless”. The word “therapeutically” is used here in its ordinary sense, that is, the intention is therapeutic when the aim is to treat the patient for the purpose of curing or ameliorating his condition.

It should be noted that we have retained as an additional condition, that the treatment in question is not required if it is not in the best interests of the patient. It can happen that a treatment that has become therapeutically useless, may nevertheless be justified on the grounds of patient interests other than treatment of the medical problem as such. The patient may, for example, wish more time in order to see a relative for one last time, prepare a will or put his or her affairs in order. These would be examples of what in our view can constitute the “best interests” of the patient in this context.

In response to another comment we decided to eliminate the phrase “... except in accordance with the expressed wishes of this person” from the second paragraph. It was felt that that phrase might have been wrongly interpreted to mean that a physician who refused to consent to a patient’s express desire for a treatment that was medically counter-indicated in the circumstances could be held criminally liable just for not continuing it.

Basically, then, the proposed amendment incorporates the Commission’s major recommendations. The first paragraph merely expresses the present legal rule. Patients are masters of their own decisions concerning



themselves. If they have expressed a desire to discontinue treatment already in progress or not to undergo treatment, physicians must then respect that decision. This expression of will is a question of fact. The patient can express it orally or in writing, the latter for example by means of a “living will”. Though such living wills are without any binding legal effect in Canadian jurisdictions, they may nevertheless serve as a basis for the interpretation of a patient’s wishes. Sanctions that might be imposed on the physician if he bypasses the patient’s wishes are already contained in various provisions of the *Criminal Code*. In any case, he could be charged with assault.

The second paragraph states the principle that a physician cannot be charged under the provisions of the *Criminal Code* if he ceases to administer a treatment or decides not to administer a treatment which, in the circumstances, has become therapeutically useless and not in the patient’s interest. This would be the case, for example, where artificial ventilation was continued for a patient whose cerebral functions had already undergone irreversible cessation.

This would also be the case when a physician who, in order to avoid prolonging the death agony of one of his patients, decides to discontinue antibiotics being given to treat his pneumonia. A further example would be the case of a surgeon who decides not to operate to correct a newborn’s deformity because, even if the operation were successful, the infant could not survive his other medical problems.

For reasons explained earlier, this provision applies equally to competent and incompetent patients. Moreover, it does not spell out in detail how the physician should make the decision nor who should be consulted. To comply with the general criminal law standard, those details are not relevant, as long as it can be shown that the treatment was therapeutically useful in the circumstances, made in the best interests of the patient, and not against that patient’s wishes.

**199.2 Nothing in sections 14, 45, 198, 199 and 229 shall be interpreted as preventing a physician from undertaking or obliging him to cease administering appropriate palliative care intended to eliminate or to relieve the suffering of a person, for the sole reason that such care or measures are likely to shorten the life expectancy of this person.**

As explained above, this provision is intended to eliminate any ambiguity concerning the administration of palliative care. Thanks to a very pertinent suggestion by a medical association, the only change from the Working Paper formulation of this proposed subsection, is a slight grammatical modification in the wording to make it clear that the *Code* sections should not be interpreted as obliging a doctor to cease palliative care already commenced.

This proposal simply expresses the idea that the physician’s duty is to provide patients with appropriate palliative care when further therapeutic treatment would serve no purpose. For palliative purposes, the appropriate use of drugs, medication or other pain control treatment is legal and legitimate even if they may have the effect of shortening the patient’s life expectancy.

<p>* These sections of the <i>Criminal Code</i> have been renumbered since the Report of the Law Reform Commission in 1983.</p>
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## Appendix H

### Suggested Procedural Guidelines

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#### **R. v. Rodriguez - Supreme Court of Canada per Chief Justice Lamer [1993] 3 S.C.R. 519-579 (Dissenting judgment)**

1. An application must be made to a superior court for permission to terminate one's life.
2. The applicant must be certified by a treating physician and independent psychiatrist to be competent to make the decision to end her own life, and the physicians must certify that the applicant's decision has been made freely and voluntarily.
3. At least one of the physicians must be present with the applicant at the time the applicant commits assisted suicide.
4. The physicians must also certify that the applicant is or will become physically incapable of committing suicide unassisted, and that they have informed the applicant that he or she has a continuing right to change his or her mind about the decision to terminate life.
5. The Regional Coroner must be given notice and an opportunity to be present at the examination of the independent psychiatrist.
6. The applicant must be examined daily by one of the certifying physicians to ensure that he or she still wants to take his or her own life.
7. The constitutional exemption will expire if the dying person has not exercised the option within 31 days from the date of examination by the independent psychiatrist.
8. The act causing the death of the applicant must be that of the applicant him or herself, and not of anyone else.

#### **Commentary**

The Chief Justice indicated that his suggested conditions were tailored to meet the particular circumstances of Sue Rodriguez and while they could serve as guidelines for future petitioners in similar circumstances, each application would have to be considered in its own individual context.

Mr. Justice Cory concurred with the Chief Justice's proposed guidelines. Madam Justice McLachlin also concurred, for the most part, with the conditions as set out by the Chief Justice. However, she was of the view that some of the conditions he proposed might not be essential in all cases. She stated that the necessary conditions could vary from case to case. The critical requirement, in all applications, would be that the applicant freely and voluntarily consent to the assisted suicide.



**R. v. Rodriguez - British Columbia Court of Appeal per Chief Justice McEachern (1993) 76 BCLR (2d) 145-168(Dissenting judgment)**

1. An application must be made to a superior court for permission to terminate one's life.
2. The applicant must be mentally competent to make a decision to end his or her own life. Such competence must be certified in writing by a treating physician and by an independent psychiatrist who has examined the applicant not more than 24 hours before arrangements are put in place which will permit the life termination and such arrangements must only be operative while one of the said physicians is actually present with the person. (The certificate must include the professional opinion of the physicians that, not only is the applicant competent, but also that, in the opinion of such physicians, the desire to end his or her life is sincere and that the decision has been reached of the applicant's own free will without pressure or influence from any source other than the present circumstances. There must be some assurance that the individual has not changed his or her mind since making the earlier declarations.)
3. The applicant must be terminally ill and near death and there must be no hope of recovering. A condition should be that the applicant is or, but for medication, would be suffering unbearable physical pain or severe psychological distress. The applicant must be informed and must fully understand that he or she has a continuing right to change his or her mind about terminating life. The physicians must also indicate when, in their opinion, the applicant would likely die: (a) if palliative care is being or would be administered, and (b) if palliative care is not being administered.
4. Not less than 3 days before any psychiatrist examines the individual for the purposes of preparing the said certificate, notice must be given to the Regional Coroner for the area or district where the individual is to be examined, and the Regional Coroner or his or her nominee, who must be a physician, may be present at the examination of the person by a psychiatrist in order to be satisfied that the person does, indeed, have mental competence to decide and did, in fact, decide to terminate his or her life.
5. One of the physicians giving any certificate as aforesaid must re-examine the person each day after the above-mentioned arrangements are put in place to ensure that the person does not evidence any change in his or her intention to end life. If the suicide is carried out, such physician must furnish a further certificate to the Coroner confirming that, in his or her opinion, the person did not change his or her mind.
6. No one may assist the person to attempt to commit suicide or to commit suicide after the expiration of 31 days from the date of the first mentioned certificate and, upon the expiration of that period, any arrangements made to assist the person to end his or her life must immediately be made inoperative and discontinued. This is to ensure that the person has not changed his or her mind since the time of examination by a psychiatrist.
7. The act actually causing the death of the person must be the unassisted act of the person him or herself, and not of anyone else.

**Commentary**

Mr. Justice McEachern cautioned that the above-mentioned conditions were intended only as guidelines that could be modified depending upon the circumstances of each case.

**Canadian AIDS Society (Excerpt from brief presented to the Special Committee on Euthanasia and Assisted Suicide)**

1. Committees should be established to review all end-of-life options.

2. The state of mind of each patient must not involve depression at the time the decision to end life is made.
3. The physicians and counsellors assisting in the death of the patient should have known the person being assisted for a considerable period of time prior to any agreement to assist.
4. The person seeking death should make the request repeatedly over a period of time.
5. Death should be imminent.

### **Commentary**

The foregoing guidelines were derived from a select group of the members of the Canadian AIDS Society who had taken part in a study conducted by the Canadian AIDS Society of its own members. Those proposing the above safeguards were interviewees who supported a legalization of euthanasia under specified circumstances.



### **Choice in Dying, Ottawa (Excerpt from brief presented to the Special Committee on Euthanasia and Assisted Suicide on Wednesday, June 1, 1994)**

1. Guidelines should be created with the right to self-determination being the primary consideration of any forthcoming legislation.
2. More specifically, any reform of the present laws should recognize the right to self-determination and should remove all threat of criminal sanctions for those who assist others in exercising this right.
3. Every person should have the right to:
  - (a) accept or refuse any or all medical treatment, or continuation of it.
  - (b) accept or refuse artificial life support, such as artificial methods of feeding, and maintenance of breathing and heart activity.
4. Every person who is suffering from a terminal or incurable illness should have the right to:
  - (a) decide what level of suffering is bearable;
  - (b) request and receive professional aid to hasten death, if the request is made clearly and consistently in a way that leaves no doubt about the person's wishes.
5. Advance directives should be legally recognized and followed in the event of a patient becoming mentally or physically incapable.
6. No person should be obliged to assist in the giving of aid to hasten death, but if a professional caregiver exercises the right to decline, it creates, in that same person, the obligation to refer the patient to an alternative qualified person who is willing to comply with the patient's wishes.
7. It should be a recognized duty of medical and palliative care professionals to ensure that "sympathetic" but "impartial" counselling is made available as to the full range of options open to patients. Notwithstanding the importance of counselling the patient, should a patient not wish to be counselled, then that wish must be respected.
8. Only voluntary euthanasia, which is consistent with the principle of self-determination in medical treatment, should be made legal. However, where a presently competent individual had requested voluntary euthanasia, by way of an advance directive, this request should be considered valid, provided the circumstances of its application are clearly outlined.

9. Relatives and others should be permitted to be present during the suicide without risk of penal sanctions.
10. Some form of counselling should be made available to patients dying at home as well as to patients dying in hospitals.



**Dying With Dignity (Excerpt from brief presented to the Special Committee on Euthanasia and Assisted Suicide)**

1. A request for physician-assisted death must be made by a person voluntarily and repeatedly. The request must be documented and, if possible, witnessed. The request may be in the form of a living will, durable power of attorney for health care, voluntary euthanasia declaration, or any other form of directive whether in verbal, written, or electronic form.
2. Persons competent to make treatment decisions for themselves should be presumed competent to make a request for physician-assisted death. A psychiatric or psychological assessment may be requested by the physician to confirm competency.
3. A request may be made by any competent person who is either terminally ill or in a state of chronic irreversible illness wherein the suffering, from the point of view of that person, is unbearable.
4. The person must be fully informed of all treatment options, including palliative care, and that he or she is free to change his or her mind at any time by revoking the request for physician-assisted death either verbally, in writing, or by electronic means.
5. The person's family or others designated by the person should be informed of the request to die but the final decision must be made by the person seeking death.
6. One physician, preferably the primary care physician of the person, and at least one other health care worker who has known the person for a reasonable length of time, must be consulted and must concur with the diagnosis and prognosis. (It may not always be possible to have the opinion of a second physician. In these circumstances, the other health care consultant could be a nurse, nurse practitioner, social worker or chaplain.)
7. Where possible, a team consultative approach is advisable provided there would be no risk of undue delay or suffering to the person making the request. Consensus is not essential but there must be an awareness that the person requesting assisted death is fully informed and understands the implications of the request.
8. A request by a person for physician-assisted death shall not be acted upon for at least five days after the request is made or such greater time agreed upon by the person and his or her physician. Where the person requesting physician-assisted death would be required to endure unreasonable pain or physical or psychological suffering, the five-day period may be reduced.
9. A physician, preferably the primary care physician, must always be present when the physician-assisted death is carried out and must bring about the death in the most humane and compassionate manner possible.
10. No physician shall be obliged to provide assistance. However, a physician who refuses to assist should refer the person to another qualified physician who would be prepared to act on the person's request.
11. All persons receiving physician-assisted dying must have been legal residents of Canada for at least six months.



12. Every act of physician-assisted dying must be fully documented and reported by the physician to a local coroner and a representative of the federal Ministry of Justice within 30 days from the death of the person.
13. Representatives of the federal Ministry of Justice should review each case of physician-assisted death and report annually to Parliament.
14. Parliament must ensure that the policy of physician-assisted death enacted by Parliament is being adhered to and must determine whether further safeguards are required.



**Mr. Yvon Bureau (Testimony before the Special Committee on Euthanasia and Assisted Suicide, Wednesday, May 4, 1994)**

1. The prohibitions against acts of euthanasia and assisted suicide should be maintained in the *Criminal Code* for a period of four years.
2. The proscription against assisted suicide in cases where the individual requesting death is in the final stages of life should be removed from the *Criminal Code*. Further, assistance in voluntary dying should not be considered murder or homicide since there is no victim.
3. An amendment should be made to the *Criminal Code* explicitly addressing the question of assistance in voluntary dying for persons in the final stages of their lives and penalties should be provided for persons found guilty of such practices.
4. The House of Commons should pass a statute, in 1995, providing that physicians who practise euthanasia or assistance in voluntary suicide on a person who is at the end of his or her life and who have complied with the strict and specific framework set out with regard to such practices will not be prosecuted and convicted.
5. The Department of Health and Welfare Canada, in cooperation with the provincial departments of health, should establish as soon as possible guidelines for the practice of assistance in voluntary dying. The Dutch model may be of interest in this regard. However, the procedures set out in the Netherlands for dealing with persons incapable of consenting to or refusing terminal care should not be considered at all, particularly for persons who have not drafted some form of living will.
6. Every provincial department of health should adopt a policy on special care and attention for all dying persons in 1995. Every health and social services institution should do the same during the course of that year.
7. The responsibility for providing adequate information on the advantages, disadvantages, risks and alternatives to the numerous possible treatment alternatives should be assigned to all health care institutions through their teams of professionals and not to one profession alone. The risk of abuse will be greatly reduced if the responsibility for decision-making lies with an entire multidisciplinary team.
8. Every provincial department of health should strongly recommend that all its institutions inform their users of their rights and responsibilities to refuse and request cessation of treatment. They should also be made aware of their right to die without pain. An advertising campaign should be conducted for this purpose as soon as possible.
9. Users of the health care institutions should be informed about the ways in which they may express their last wishes. They must be made aware that they should appoint others to ensure that their wishes are honoured.



10. A specific section concerning the patient's last wishes should be made in each patient's file and these files should be kept with the various health care institutions. The last wishes of a patient may, for example, be expressed through a living will, or a power of attorney in case of incapacity.

11. The Department of Health and Welfare Canada should invest several billions of dollars to enable all persons who so wish to die at home. This investment will produce enormous returns on all levels.

12. Every provincial department of health should establish a 24-hour 1-800 number to answer questions of dying persons and their families and caregivers on their rights, duties, responsibilities and freedoms. In Quebec, Info-Santé could provide this service.

13. The dying persons should be the focus of the information and decision-making process, notwithstanding any declaration of incompetence to make decisions. The dying person and his or her freedom should take precedence over treatment. The main concern that should lie with health care professionals should be to ensure that free and informed consent or refusal for every treatment offered is obtained and that consent or refusal is honoured in all cases.

14. The consent of the patient's family should be obtained but it should not be mandatory or necessary. A minimal age should be established whereby the family of the patient would not have the right to be informed or to make treatment decisions without authorization from the dying patient.

### **Commentary**

The above-noted proposals, according to Mr. Bureau, would ensure that it would still be possible to prosecute and convict persons who have not complied with the preconditions established for the practices of euthanasia and assistance in dying to be permitted. Expressing free and informed consent or refusal through advanced directives would be recognized as would a power of attorney for the incapacitated. Quality of life would no longer be determined by the number of treatments provided. The dying person would be in a position to decide what is an acceptable quality of life for him or herself. In this way, there would be fewer conflicts of interest for health care professionals and a reduction in the administration of unnecessary treatments for the terminally ill.



**Mr. Russel D. Ogden (Excerpt from paper prepared for the American Society of Criminology Conference entitled "Safeguarding Euthanasia: Legislative Proposals in Canada and the United States" at p.15)**

### **Commentary**

Mr. Ogden proposed certain minimal safeguards that, in his view, would be essential to incorporate in any form of right-to-die legislation.

1. The patient must give informed consent.
2. There must be a clinical consensus concerning the prognosis for the patient.
3. Counselling should be available for the patient and other persons involved with respect to the following: possible treatment alternatives, the diagnosis and prognosis, the consequences of the aid-in-dying procedure, the underlying motivation for requesting euthanasia, and alternative care environments.

4. An assessment should be required regarding the possible presence of treatable depression.
5. The voluntary participation of the patient and his or her physicians is necessary.
6. An ethical review should take place in all cases.
7. There should be waiting period restrictions.
8. The implementation of the aid-in-dying procedure should be supervised.
9. An independent third party should witness the application for aid-in-dying.
10. Restrictions should be placed on who is eligible to request aid-in-dying.
11. Requests for aid-in-dying and acts of aid-in-dying should be reported in all cases.
12. A formal review mechanism should be established.



**The Humanist Association of Canada (Excerpt from brief presented to the Special Committee on Euthanasia and Assisted Suicide)**

1. All health care facilities must be required to provide, in addition to physical care, adequate psychological and emotional support to all patients and, in particular, to those who are seriously ill or incapacitated.
2. Requesters for assisted suicide should be conscious and able to affirm or re-affirm the desire to die.
3. The desire to terminate the life of the individual could be expressed in writing, on audiotape, or by any other method that would clearly indicate the wishes of the requester.
4. Independent witnesses should be present.
5. The requester must have made the same request repeatedly and must have been counselled regarding the implications of the decision being made.
6. A physician who assists in a suicide must be required to document, in consultation with other medical personnel, the circumstances in which the requester came to ask for assistance in dying.
7. Where possible, the mechanism causing death should be such that the requester may trigger that mechanism of his or her own accord.
8. Ultimately, the decision to die and the time and manner of death should rest entirely with the requester.



**Mr. Réjean Carrier (Testimony before the Special Committee on Euthanasia and Assisted Suicide, Wednesday, April 27, 1994.)**

**Commentary**

Mr. Carrier is an opponent of euthanasia and, as such, he did not propose any comprehensive list of guidelines. However, he did, informally, suggest some conditions that, in his view, would be essential if present laws were to be changed at some point.

1. The patient must fail to respond to medication for controlling physical pain.

2. The attending physician should make this diagnosis (non-responsive to medication) with another physician(s).
3. The patient should describe the suffering as intolerable.
4. The decision to respond positively to a request for euthanasia should be made by an interdisciplinary team.
5. The interdisciplinary team should be composed of people of various or similar professions that interact with each other in order to decide on the best course of action in each case.
6. National standards should not be developed for dealing with exceptional cases where palliative care is not effective. A lack of criteria in this regard would force institutions to find solutions, quite apart from euthanasia and assisted suicide, that may be acceptable.



**Mr. R. Scott Rowand (Testimony before the Special Committee on Euthanasia and Assisted Suicide, June 8, 1994)**

1. Any legalization of euthanasia and assisted suicide should be limited to a consideration of requests initiated by competent patients where the fact of competence has been determined by a specialist in psychiatry.
2. Care should be taken to explore other options such as enhanced palliative care and pain control.
3. Consultation with a hospital ethics committee should be required to assure that procedural steps have been followed and adequate safeguards are in place to prevent abuse.
4. The entire process should be supervised by the Office of the Coroner or Medical Examiner.



**The British Columbia Civil Liberties Association (Testimony before the Special Committee on Euthanasia and Assisted Suicide, Monday, September 26, 1994.)**

[A suboption in the creation of defences to criminal prosecution would be] the provision of an absolute defence for assisted suicide and active voluntary euthanasia when certain criteria have been met. The problem with this solution is that it would authorize the provision of aid in dying only after the fact. As a result, we think it would offer insufficient comfort for physicians to come forward and offer services that we believe ought to be available to all Canadians.

This suboption would require Parliament to set out *de facto* the provisions which must be set out anyway in any regulatory scheme. We believe that setting out a regulatory scheme, amending the *Criminal Code* to specifically provide for the conditions under which each of these practices and services can be offered by physicians, is the way Parliament should go.



**The Council on Aging (Testimony before the Special Committee on Euthanasia and Assisted Suicide, Friday, January 13, 1995.)**

In addition to recommendations for safeguards already presented by various groups, the Senate committee might consider the following:

First, there must be an informed consent for assisted suicide or euthanasia with requirements similar in principle to those required for an informed consent for medical treatment. The requirement of informed consent should be extended to include appropriate advice; that is, alternatives such as palliative care, by not only physicians but also by other professionals such as psychologists, physiotherapists, nurses, pastoral care workers, et cetera, who are skilled and compassionate in caring for the terminally ill.

Second it should be demonstrated that there is no self-interest in those giving advice. This requirement could be met by the approval of a disinterested third party such as a judge or a board.

Third, consent should not be given under duress.

Fourth, the decision should be given with appropriate written formulations.

Fifth, if the decision is made by a committee, or the attorney for personal care, it should be based on a prior directive and the above requirements should be fulfilled.

In summary, first, the Council on Aging strongly supports the need for palliative care to be available nationwide and in a variety of environments, both urban and rural. Education concerning the principles of palliative care should be available for physicians, other health care providers and the general public.

Second, the Council on Aging believes that legislation enshrining the legitimacy of advance directives based on informed choices should be available throughout Canada.

Third, the Council on Aging maintains that if adequate palliative care services were available and individuals have the choice to state their preferences for treatment in an advance directive prior to becoming terminally ill, the number of individuals who would consider euthanasia or assisted suicide would be minimal.

Fourth, the Council on Aging recognizes the fact that despite being given the best care possible, a small percentage of patients cannot be maintained in a pain-controlled existence. There are different pain thresholds, different abilities to tolerate suffering and different philosophies concerning the bearing of pain.

Fifth, the Council on Aging agrees with physician intervention to ease pain and suffering even if it shortens life. However, in this case, the purpose of the intervention should be pain control, not euthanasia or assisted suicide.

Sixth, the Council on Aging will not take a position on the legalization of assisted suicide and euthanasia. Among the members there were the following perspectives: Some members were prepared to accept the concepts of assisted suicide and euthanasia, provided adequate safeguards were established to protect the vulnerable; some members flatly disagreed with these concepts; and other members voiced the opinion that although they would not wish to terminate their own lives in this manner, it was an individual's right to make his or her decisions.

Finally, the Council on Aging suggests that if euthanasia and assisted suicide were made legal, this should be realized through changes in the *Criminal Code* with adequate safeguards which must be reasonable, enforceable and enforced.



**Canadian Bar Association (Excerpt from brief presented to the Special Committee on Euthanasia and Assisted Suicide, March 1995)**

**Safeguards**

If the Committee recommends revising the existing law to permit euthanasia or assisted suicide with certain procedural safeguards to avoid abuse, certain constitutional issues would first have to be addressed. In particular, attention should be paid to the extent to which the criminal law power under the Constitution can properly be used to create an administrative regime for personal rights. The Supreme Court of Canada in *R. v. Morgentaler* [1988] 1 S.C.R. 30 struck down a *Criminal Code* provision that limited access to abortion services on the ground that the complex procedure to obtain abortions, and the uneven access to such services across the country, violated the rights of women under section 7 of the *Charter*. Similarly, any regime recommended by this Committee should be such as can be equally available throughout the country.

It is also recommended that, to avoid abuse, any protocol to permit euthanasia or assisted suicide with certain procedural safeguards must:

1. provide for review or scrutiny prior to the act; **and**
2. provide for review or scrutiny **after** the act.

**Scrutiny Prior to the Act**

The decision to request euthanasia or assisted suicide is a personal one, and the safeguard must be structured to minimize intrusion into the individual's life, while protecting against possible abuses. The safeguard mechanisms may be different depending upon whether it is a physician or other individual (family member or friend) who is to be involved.

The question of who assesses the person's competence, and on what basis, is an important one. There are likely to be difficulties in assessing this, particularly from a psychiatric perspective (for example, defining what constitutes depression). Given the distress, even disorientation caused by catastrophic illness and the pain of dying, difficulties are bound to arise in trying to ascertain whether the voice being heard is truly the person's voice.

The medical profession currently has responsibility for competence assessment with respect to health care decisions. It may accordingly be appropriate for them to retain responsibility with respect to assessing competence to request euthanasia or assisted suicide. However, safeguards should require a second medical opinion as to the patient's competence to make this decision, as well as the voluntariness of the decision. It may also be appropriate to require scrutiny by a non-medical person, such as a judicial or quasi-judicial officer.

**Scrutiny After the Act**

Decisions to withdraw treatment are highly public decisions, in that they are usually made in hospitals, and are attended by several individuals and substantial documentation in records and charts. By contrast, the decision to die is or can be a very private one.

Both to safeguard against abuse with respect to individuals, and to measure the broader social impact of the policy, it is suggested that any system of safeguards could include an obligation that all acts of euthanasia or assisted suicide be reported to a legislated review board with medical, legal and lay members, and that the board be required to report to Parliament on a regular basis.



## Appendix I

# British Columbia Crown Counsel Policy Guidelines

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*Note: The enactment of the Criminal Code is a federal jurisdiction, however, the administration of justice is a provincial responsibility. Therefore, the Attorney-General of each province has discretion as to whether charges are laid. In accordance with these responsibilities, British Columbia has developed the following guidelines:*

*1. Active Euthanasia and Assisted Suicide Crown Counsel Policy Manual, Province of British Columbia, Ministry of Attorney General, Criminal Justice Branch (Policy 11-3-93, File no. 56880-01, Eut 1)*

These guidelines apply in cases where a police report to Crown Counsel reveals a person, motivated by compassion for the deceased, participated in causing a death.

In considering these cases, Crown Counsel will apply the general Charge Approval Policy and will only approve a prosecution where there is a substantial likelihood of conviction and the public interest requires a prosecution.

Given the complex nature of the legal issues and the evolution of palliative care, charging decisions will be made on a case-by-case basis following an examination of the facts and circumstances of each case and taking into consideration the following additional factors in applying the general Charge Approval Policy. The charging decision will be made by Regional Crown Counsel in consultation with the Director of Policy and Legal Services.

### Substantial Likelihood of Conviction

In considering whether there is a substantial likelihood of conviction, Crown Counsel must characterize the conduct of the person involved in a death. For the purpose of this policy, this conduct, and the resulting legal consequences are divided into four categories.

**“Active-euthanasia”** means intentionally terminating early, for compassionate reasons, the life of a person who is terminally ill or whose suffering is unbearable. This conduct is culpable homicide under section 222 of the *Criminal Code* and may constitute the offences of murder, manslaughter or criminal negligence causing death.

**“Assisted suicide”** means advising, encouraging or assisting another person to perform an act that intentionally brings about his or her own death. This conduct is an offence of either counselling or aiding suicide under section 241 of the *Criminal Code*.

**“palliative care”** means a qualified medical practitioner, or a person acting under the general supervision of a qualified medical practitioner, administering medication or other treatment to a terminally ill patient with

the intention of relieving pain or suffering even though this may hasten death. This conduct, when provided or administered according to accepted ethical medical standards, is not subject to criminal prosecution.

**“withholding or withdrawing treatment”** means a qualified medical practitioner, with consent by or on behalf of the patient, discontinuing or not intervening with medical procedures to prolong life beyond its natural length. This conduct, when provided or administered according to accepted ethical medical standards, is not subject to criminal prosecution.

The factors to be considered by Crown Counsel in characterizing the conduct of the person involved in a death include:

1. The provable intention of the person who caused, accelerated, counselled or assisted the death, recognizing the criminal intents necessary for murder and counselling or aiding suicide.
2. Where the conduct involves a physician and a patient, the position of the Canadian Medical Association and expert medical opinions as to generally recognized and accepted ethical medical practices:

*...there are conditions of ill health and impending inevitable death where an order...by the attending doctor of “no resuscitation” is appropriate and ethically acceptable.<sup>1</sup>*

*...an ethical physician “will allow death to occur with dignity and comfort when death of the body appears to be inevitable [and] may support the body when clinical death of the brain has occurred, but need not prolong life by unusual or heroic means”.<sup>2</sup>*

*The withholding or withdrawal of inappropriate, futile or unwanted medical treatment and the provision of compassionate palliative care, even when that shortens life, is considered good and ethical medical practice.<sup>3</sup>*

3. Whether, with reference to the following considerations, the acts of a qualified medical practitioner, or a person acting under the general supervision of a qualified medical practitioner, constitute “palliative care”;

a) As stated by Mr. Justice Sopinka, in *Rodriguez v. Attorney General of Canada et al*, Supreme Court of Canada, September 30, 1993:

*The administration of drugs designed for pain control in dosages which the physician knows will hasten death constitutes active contribution to death by any standard. However, the distinction drawn here is one based upon intention - in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death. The Law Reform Commission, although it recommended the continued criminal prohibition of both euthanasia and assisted suicide, stated, at p. 70 of the Working Paper, that a doctor should never refuse palliative care to a terminally ill person only because it may hasten death. In my view, distinctions based upon intent are important, and in fact form the basis of our criminal law. While factually the distinction may, at times, be difficult to draw, legally it is clear.... (at page 34)*

- b) whether the patient was terminally ill and near death with no hope of recovery;
- c) whether the patient’s condition was associated with severe and unrelenting suffering;
- d) whether accepted ethical medical practices were followed; and
- e) whether the patient was participating in a palliative care program or palliative care treatment plan.

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1 Canadian Medical Association, Canadian Physicians and Euthanasia, 1993, p. 5

2 *Ibid*, p. 19 quoting from the Canadian Medical Association: *Code of Ethics*, CMA, Ottawa, 1990: Items 18 and 19.

3 *Ibid*, p. 20

4. Whether, with reference to the following considerations, the acts of a qualified medical practitioner constitute “withholding or withdrawing treatment”:

a) Under the common law, a physician must accept the patient’s instructions to refuse or discontinue medical treatment although such treatment may well prolong life. Canadian Courts have recognized this right, see *Malette v. Shulman* (1990) 72 O.R. (2d) 417 (Ont. C.A.). As stated by Sopinka, J. in *Rodriguez*, supra:

*To continue to treat the patient when the patient has withdrawn consent to that treatment constitutes battery (Ciarlariello and Nancy B., supra.) The doctor is therefore not required to make a choice which will result in the patient’s death as he would be if he chose to assist a suicide or to perform active euthanasia.(at page 34)*

b) where the deceased refused treatment or revoked consent to the treatment, whether such refusal or revocation was fully informed and freely done. This will include consideration of whether:

- i) the patient clearly understood his or her medical condition and that it may result in death if treatment was discontinued or not engaged;
- ii) the patient was mentally incompetent, depressed, or otherwise vulnerable;
- iii) the patient’s refusal of treatment or revocation of consent and the act of withholding or withdrawing treatment occurred contemporaneously;
- iv) the patient was informed and understood his or her ongoing right to reconsider the refusal or revocation of consent;
- v) there is any evidence the patient reconsidered his or her initial refusal or revocation of consent;
- vi) anyone pressured the patient to refuse treatment or revoke consent to the treatment; and
- vii) accepted ethical medical practices were followed.

c) where the deceased was unable to refuse treatment or revoke consent to treatment, consideration of whether:

- i) there were instructions given to the qualified medical practitioner by another person or entity authorized to refuse treatment or revoke consent to treatment on behalf of the patient, for example, the existence of a court order or power of attorney for health care;
- ii) there was evidence that withholding or withdrawal of treatment was what the patient would have requested had he or she been able to refuse treatment or revoke consent to treatment; and
- iii) accepted ethical medical practices were followed.

## Public Interest

If Crown Counsel has determined there is a substantial likelihood of conviction, he or she must also be satisfied the public interest requires a prosecution. In determining the public interest, the specific factors to be considered include, but are not restricted to, the public interest factors outlined in the general Charge Approval Policy and the following:

1. The importance of supporting proper professional and ethical standards within the health care professions;
2. Society’s interest in the protection of vulnerable persons; and
3. Society’s interest in protecting the sanctity of human life, recognizing this does not require life to be preserved at all cost.

*2. Quality Control - Charge Approval Policy Crown Counsel Policy Manual,  
Province of British Columbia, Ministry of Attorney General, Criminal Justice  
Branch (Policy 2-26-91, File no. 55100-00)*

Section 504 of the *Criminal Code* allows anyone to lay, and directs a justice to receive, an Information alleging a criminal offence. In British Columbia, it has long been the policy of the Ministry of Attorney General that Crown Counsel review all allegations of criminal conduct and apply a single, consistent charging standard before charges are approved and an Information laid. This system of charge approval has received the endorsement of the Justice Reform Commission and the Discretion to Prosecute Inquiry.

The charging standard and procedure to be followed are set out below. Any Informations that are laid without the prior approval of Crown Counsel should be dealt with under the private prosecutions policy, see PRI 1.

## **A. Charge Standard**

Allegations must be examined to determine whether there is a substantial likelihood of conviction; and if so, whether the public interest requires a prosecution of the accused.

### **1. Substantial Likelihood of Conviction**

In determining whether a charge should be laid, Counsel must first conclude that it is likely there will be a conviction after considering all relevant matters including the available evidence, the anticipated defence and the applicable law. A substantial likelihood of conviction is significantly more a *prima facie* case, but considerably less than a virtual certainty of conviction.

During the charge approval process, Crown Counsel does not have the benefit of hearing the testimony of Crown witnesses, either in direct or cross-examination. Nor does Crown Counsel have the benefit of hearing the defence evidence, if any. During the course of a trial, the Crown's case may be materially stronger or weaker than counsel's initial assessment at the early charge approval stage. For this reason, Crown Counsel must be flexible in applying the substantial likelihood of conviction standard recognizing that the more serious the allegation, the greater the interests of justice in ensuring that provable charges are prosecuted.

### **2. Public Interest**

Counsel must next determine whether the public interest dictates a prosecution. There are a number of factors counsel should consider in assessing the public interest in a prosecution:

- (a) The nature and seriousness of the allegations;
- (b) the harm caused to the victim, if any;
- (c) the personal circumstances of the accused, including his or her criminal record;
- (d) the likelihood of achieving the desired result without a court proceeding, including an assessment of the available alternatives to prosecution; and
- (e) the cost of a prosecution compared to the social benefit to be gained by it. This will include considerations such as the degree to which this offence (as opposed to this offender) represents a community problem which cannot be effectively dealt with otherwise.

In considering the public interest hard and fast rules cannot be imposed and flexibility in decision making at the local level is essential if the Ministry is to respond to the legitimate concerns of each community.



## **B. Applying the Charge Standard**

If Counsel is to accurately apply the charge standard, the Report to Crown Counsel (RTCC) must provide an accurate and detailed statement of the evidence available. The following are the basic requirements for every RTCC:

- (a) A comprehensive description of the evidence supporting each element of the suggested charge(s);
- (b) where the evidence of a civilian witness is necessary to prove an essential element of the charge (except for minor offenses), a copy of that person's written statement;
- (c) necessary evidence check sheets;
- (d) copies of all documents required to prove the charge(s);
- (e) a detailed summary or written copy of the accused's statement(s); and
- (f) accused's criminal record (if any).

There may be cases where the RTCC will not comply with the quality control standards. The RTCC should then be returned to the investigator with a request for additional information before a charge is approved. If the accused is in custody, Crown should not seek to detain the accused in custody without sufficient written material from the police to justify both the charge and the detention.

If the offence is serious and there is sufficient evidence to charge the detained accused but insufficient information to determine Crown's position on release, resort may be had to s. 516 to adjourn the show cause. This should be used only where it appears necessary to protect the public.

In applying the charge standard Crown Counsel's important obligations are to:

- (i) make the decision in a timely manner;
- (ii) record the reasons for the decision; and
- (iii) where appropriate, communicate with those affected, including the police, so that they understand the reasons for the decision.





## Appendix J

# Citations for Advance Directives Legislation in Canada

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<b>Ontario</b>	Bill 109, <i>An Act respecting Consent to Treatment Act</i> , Bill 108, <i>An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care</i> , Bill 74, <i>An Act Respecting the Provision of Advocacy Services to Vulnerable Persons</i> , and Bill 110, <i>Consent and Capacity Statute Law Amendment Act</i> 2d Session, 35th Leg Ont, 1992 - passed and proclaimed.
<b>Quebec</b>	<i>Public Curator Act</i> , SQ 1989, c.54 - passed and proclaimed. <i>Civil Code of Quebec</i> , LRQ c. 64 1991, art. 10-34.
<b>Nova Scotia</b>	<i>Medical Consent Act</i> RSNS 1988 c. 14 in RSNS 1989, c.279 - passed and proclaimed.
<b>New Brunswick</b>	No legislation in place but an Advance Health Care Directives Committee has studied the issue and has reported to the Minister Justice regarding the development and implementation of advance directives. Minister of Justice intends to study the report and determine if legislation is necessary.
<b>Manitoba</b>	Bill 73, <i>The Health Care Directives Act</i> SM 1992, c.33 - C.H27 of the continuing Consolidation of the Statutes of Manitoba, 1989.
<b>British Columbia</b>	<i>Representation Agreement Act</i> , S.B.C. 1993, c.67 (Bill 48, 1993) combined with <i>Adult Guardianship Act</i> , S.B.C. 1993, c. 35 (Bill 49); <i>Public Guardian and Trustee Act</i> , S.B.C. 1993, c.64 (Bill 50, 1993); and <i>Health Care (Consent) and Care Facility (Admission) Act</i> , S.B.C. 1993, c.48 (Bill 51, 1993) - all passed but not yet proclaimed
<b>Prince Edward Island</b>	Nothing in place or planning stages.
<b>Saskatchewan</b>	Nothing in place or planning stages.
<b>Alberta</b>	Bill 58, <i>Advance Directives Act</i> dropped from the <i>Order Paper</i> when the legislative session ended in November, 1994. Health Minister currently receiving and analysing public input received from a discussion paper on advance directives.

**Newfoundland**

Bill 41, *An Act Respecting Advance Health Care Directives and the Appointment of Substitute Health Care Decision Makers* - dropped from the *Order Paper* when legislative session ended in March, 1995. Reintroduced as Bill 1 *An Act Respecting Advance Health Care Directives and the Appointment of Substitute Health Care Decision Makers*. First reading on March 16, 1995. Currently awaiting Committee study.

**Northwest Territories**

No legislation directly governing this issue at present or in the works. However, the Department of Health and Human Services has initiated the development of Standards and Procedures for Advanced Treatment Directives for both Coordinated Home Care Programs and Facility based Long Term Care Programs.

**Yukon**

Nothing in place or planning stages.

## Appendix K

### Sources for Sample Directives

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#### Ontario

Publications Ontario (For copies of the *Consent to Treatment Act*)  
880 Bay Street  
Toronto, Ontario  
M7A 1N8  
(416) 326-5300  
toll free in Ontario 1-800-668-9938

Health Information Centre (For information on the *Consent to Treatment Act*)  
Ministry of Health  
2195 Yonge Street, 6th floor  
Toronto, Ontario  
M4S 2B2  
Phone (416) 327-7730  
toll free in Ontario 1-800-461-2036  
TDD/TTY 1-800-387-5559  
Fax (416) 314-8721

Substitute Decisions Project (For information about the *Substitute Decisions Act*)  
Office of the Public Trustee  
Ministry of the Attorney General  
145 Queen Street West, 6th floor  
Toronto, Ontario  
M5H 2N8  
Phone (416) 314-2989  
TDD/TTY (416) 314-2687  
Fax (416) 314-6190

Advocacy Project (For information about the *Advocacy Act*)  
Ministry of Citizenship  
700 Bay Street, Suite 204  
Toronto, Ontario  
M5G 1Z6  
Phone (416) 314-8910  
toll free in Ontario 1-800-665-9092  
TDD/TTY (416) 314-9018  
Fax (416) 314-8935



## Sources for Sample Directives

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### Quebec

My Mandate in Case of Inability  
Le Curateur public du Québec  
Les publications du Québec  
1279, Boul. Charest Ouest  
Quebec (Quebec)  
G1N 4K7

### Nova Scotia

Office of the Legal Counsel  
Department of Health  
Box 488  
Halifax, Nova Scotia  
B3J 2R8  
Phone (902) 424-7729  
Fax (902) 424-0719

### Manitoba

Legislative Analyst  
Manitoba Health  
201-800 Portage Avenue  
Winnipeg, Manitoba  
R3G 0N4  
Phone (204) 945-5835  
Fax (204) 945-1020

### British Columbia

Minister of the Attorney-General  
609 Broughton Street  
Victoria, British Columbia  
V8V 1X4

Minister of Health and Minister Responsible for Seniors  
1515 Blanshard Street  
Victoria, British Columbia  
V8W 3C8

## Appendix L

### Summaries of Some Relevant Canadian Court Decisions

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#### **Rodriguez v. British Columbia (Attorney-General) 3 SCR (1993) 519.**

The appellant, Sue Rodriguez, a 42-year-old mother, suffers from amyotrophic lateral sclerosis. Her condition is rapidly deteriorating and she will soon lose the ability to swallow, speak, walk and move her body without assistance. Thereafter she will lose the capacity to breathe without a respirator, to eat without a gastrostomy and will eventually become confined to a bed. Her life expectancy is between two and fourteen months. The appellant does not wish to die so long as she still has the capacity to enjoy life, but wishes that a qualified physician be allowed to set up technological means by which she might, when she is no longer able to enjoy life, by her own hand, at the time of her choosing, end her life. The appellant applied to the Supreme Court of British Columbia for an order that s. 241(b) of the *Criminal Code*, which prohibits the giving of assistance to commit suicide, be declared invalid on the ground that it violates her rights under ss. 7, 12 and 15(1) of the *Charter*, and is therefore, to the extent it precludes a terminally ill person from committing “physician-assisted” suicide, of no force and effect by virtue of s. 52(1) of the *Constitution Act, 1982*. The court dismissed the appellant’s application and the majority of the Court of Appeal affirmed the judgment.

*Held* (Lamer C.J. and L’Heureux-Dubé, Cory and McLachlin JJ. dissenting): The appeal should be dismissed. Section 241(b) of the *Code* is constitutional.

*Per* La Forest, Sopinka, Gonthier, Iacobucci and Major JJ.: The appellant’s claim under s. 7 of the *Charter* is based on an alleged violation of her liberty and security of the person interests. These interests cannot be divorced from the sanctity of life, which is the third value protected by s. 7. Even when death appears imminent, seeking to control the manner and timing of one’s death constitutes a conscious choice of death over life. It follows that life as a value is also engaged in the present case. Appellant’s security of the person interest must be considered in light of the other values mentioned in s. 7. Security of the person in s. 7 encompasses notions of personal autonomy (at least with respect to the right to make choices concerning one’s own body), control over one’s physical and psychological integrity which is free from state interference, and basic human dignity. The prohibition in s. 241(b), which is a sufficient interaction with the justice system to engage the provisions of s. 7, deprives the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person. Any resulting deprivation, however, is not contrary to the principles of fundamental justice. The same conclusion is applicable with respect to any liberty interest which may be involved.

The expression “principles of fundamental justice” in s. 7 of the *Charter* implies that there is some consensus that these principles are vital or fundamental to our societal notion of justice. They must be capable of being identified with some precision and applied to situations in a manner which yields an understandable result. They must also be legal principles. To discern the principles of fundamental justice governing a particular case, it is helpful to review the common law and the legislative history of the offence in question and, in particular, the rationale behind the practice itself (here, the continued criminalization of assisted suicide) and the principles which underlie it. It is also appropriate to consider the state interest. Fundamental justice requires that a fair balance be struck between the interests of the state and those of the individual. The respect for human dignity, while one of the underlying principles upon which our society is based, is not a principle of fundamental justice within the meaning of s. 7.

Assisted suicide, outlawed under the common law, has been prohibited by Parliament since the adoption of Canada's first *Criminal Code*. The long-standing blanket prohibition in s. 241(b), which fulfils the government's objective of protecting the vulnerable, is grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken. This state policy is part of our fundamental conception of the sanctity of life. A blanket prohibition on assisted suicide similar to that in s. 241(b) also seems to be the norm among Western democracies, and such a prohibition has never been adjudged to be unconstitutional or contrary to fundamental human rights. These societies, including Canada, recognize and generally apply the principle of the sanctity of life subject to narrow exceptions where notions of personal autonomy and dignity must prevail. Distinctions between passive and active forms of intervention in the dying process continue to be drawn and assisted suicide in situations such as the appellant's is prohibited with few exceptions. No consensus can be found in favour of the decriminalization of assisted suicide. To the extent that there is a consensus, it is that human life must be respected. This consensus finds legal expression in our legal system which prohibits capital punishment. The prohibition against assisted suicide serves a similar purpose. Parliament's repeal of the offence of attempted suicide from the *Criminal Code* was not a recognition that suicide was to be accepted within Canadian society. Rather, this action merely reflected the recognition that the criminal law was an ineffectual and inappropriate tool for dealing with suicide attempts. Given the concerns about abuse and the great difficulty in creating appropriate safeguards, the blanket prohibition on assisted suicide is not arbitrary or unfair. The prohibition relates to the state's interest in protecting the vulnerable and is reflective of fundamental values at play in our society. Section 241(b) therefore does not infringe s. 7 of the *Charter*.

As well, s. 241(b) of the *Code* does not infringe s. 12 of the *Charter*. The appellant is not subjected by the state to any form of cruel and unusual treatment or punishment. Even assuming that "treatment" within the meaning of s. 12 may include that imposed by the state in contexts other than penal or quasi-penal, a mere prohibition by the state on certain action cannot constitute "treatment" under s. 12. There must be some more active state process in operation, involving an exercise of state control over the individual, whether it be positive action, inaction or prohibition. To hold that the criminal prohibition in s. 241(b), without the appellant being in any way subject to the state administrative or justice system, falls within the bounds of s. 12 would stretch the ordinary meaning of being "subjected to. treatment" by the state.

It is preferable in this case not to decide the difficult and important issues raised by the application of s. 15 of the *Charter*, but rather to assume that the prohibition on assisted suicide in s. 241(b) of the *Code* infringes s. 15, since any infringement of s. 15 by s. 241(b) is clearly justified under s. 1 of the *Charter*. Section 241(b) has a pressing and substantial legislative objective and meets the proportionality test. A prohibition on giving assistance to commit suicide is rationally connected to the purpose of s. 241(b), which is to protect and maintain respect for human life. This protection is grounded on a substantial consensus among western countries, medical organizations and our own Law Reform Commission that in order to protect life and those who are vulnerable in society effectively, a prohibition without exception on the giving of assistance to commit suicide is the best approach. Attempts to modify this approach by creating exceptions or formulating safeguards to prevent excesses have been unsatisfactory. Section 241(b) is thus not overbroad since there is no halfway measure that could be relied upon to achieve the legislation's purpose fully. In dealing with this contentious, complex and morally laden issue, Parliament must be accorded some flexibility. In light of the significant support for s. 241(b) or for this type of legislation, the government had a reasonable basis for concluding that it had complied with the requirement of minimum impairment. Finally, the balance between the restriction and the government objective is also met.

*Per L'Heureux-Dubé and McLachlin JJ. (dissenting):* Section 241(b) of the *Code* infringes the right to security of the person included in s. 7 of the *Charter*. This right has an element of personal autonomy, which protects the dignity and privacy of individuals with respect to decisions concerning their own body. A legislative scheme which limits the right of a person to deal with her body as she chooses may violate the principles of fundamental justice under s. 7 if the limit is arbitrary. A particular limit will be arbitrary if it bears no relation to, or is inconsistent with, the objective that lies behind the legislation. When one is considering whether a law breaches the principles of fundamental justice under s. 7 by reason of arbitrariness,



the focus is on whether a legislative scheme infringes a particular person's protected interests in a way that cannot be justified having regard to the objective of this scheme. The principles of fundamental justice require that each person, considered individually, be treated fairly by the law. The fear that abuse may arise if an individual is permitted that which she is wrongly denied plays no part at the s. 7 stage. Any balancing of societal interests against the interests of the individual should take place within the confines of s. 1 of the *Charter*. Here, Parliament has put into force a legislative scheme which makes suicide lawful but assisted suicide unlawful. The effect of this distinction is to deny to some people the choice of ending their lives solely because they are physically unable to do so, preventing them from exercising the autonomy over their bodies available to other people. The denial of the ability to end their life is arbitrary and hence amounts to a limit on the right to security of the person which does not comport with the principles of fundamental justice.

Section 241(b) of the *Code* is not justified under s. 1 of the *Charter*. The practical objective of s. 241(b) is to eliminate the fear of lawful assisted suicide's being abused and resulting in the killing of persons not truly and willingly consenting to death. However, neither the fear that unless assisted suicide is prohibited, it will be used for murder, nor the fear that consent to death may not in fact be given voluntarily, is sufficient to override appellant's entitlement under s. 7 to end her life in the manner and at the time of her choosing. The safeguards in the existing provisions of the *Criminal Code* largely meet the concerns about consent. The *Code* provisions, supplemented, by way of remedy, by a stipulation requiring a court order to permit the assistance of suicide in a particular case only when the judge is satisfied that the consent is freely given, will ensure that only those who truly desire to bring their lives to an end attain assistance.

Section 15 of the *Charter* has no application in this case. This is not a case about discrimination and to treat it as such may deflect the equality jurisprudence from the true focus of s. 15.

Although some of the conditions stated by Lamer C.J. seem unnecessary in this case, the remedy proposed is generally agreed with. What is required will vary from case to case. The essential in all cases is that the judge be satisfied that if and when the assisted suicide takes place, it will be with the full and free consent of the applicant.

*Per* Lamer C.J. (dissenting): Section 241(b) of the *Code* infringes the right to equality contained in s. 15(1) of the *Charter*. While, at first sight, s. 241(b) is apparently neutral in its application, its effect creates an inequality since it prevents persons physically unable to end their lives unassisted from choosing suicide when that option is in principle available to other members of the public without contravening the law. This inequality — the deprivation of the right to choose suicide — may be characterized as a burden or disadvantage, since it limits the ability of those who are subject to this inequality to take and act upon fundamental decisions regarding their lives and persons. For them, the principles of self-determination and individual autonomy, which are of fundamental importance in our legal system, have been limited. This inequality is imposed on persons unable to end their lives unassisted solely because of a physical disability, a personal characteristic which is among the grounds of discrimination listed in s. 15(1).

Section 241(b) of the *Code* is not justifiable under s. 1 of the *Charter*. While the objective of protecting vulnerable persons from being pressured or coerced into committing suicide is sufficiently important to warrant overriding a constitutional right, s. 241(b) fails to meet the proportionality test. The prohibition of assisted suicide is rationally connected to the legislative objective, but the means chosen to carry out the objective do not impair the appellant's equality rights as little as reasonably possible. The vulnerable are effectively protected under s. 241(b) but the section is over-inclusive. Those who are not vulnerable or do not wish the state's protection are also brought within the operation of s. 241(b) solely as a result of a physical disability. An absolute prohibition that is indifferent to the individual or the circumstances cannot satisfy the constitutional duty on the government to impair the rights of persons with physical disabilities as little as reasonably possible. The fear that the decriminalization of assisted suicide will increase the risk of persons with physical disabilities being manipulated by others does not justify the over-inclusive reach of s. 241(b).

In view of the findings under s. 15(1), there is no need to address the constitutionality of the legislation under ss. 7 or 12 of the *Charter*.

Pursuant to s. 52(1) of the *Constitution Act*, 1982, s. 241(b) is declared to be of no force or effect, on the condition that the effect of this declaration be suspended for one year from the date of this judgment to give Parliament adequate time to decide what, if any, legislation should replace s. 241(b). While a personal remedy under s. 24(1) of the *Charter* is rarely available in conjuncture with action under s. 52(1), it is appropriate in this case to grant the appellant, subject to compliance with certain stated conditions, a constitutional exemption from the operation of s. 241(b) during the period of suspension. A constitutional exemption may only be granted during the period of a suspended declaration of invalidity. During that one-year suspension period, this exemption will also be available to all persons who are or will become physically unable to commit unassisted suicide and whose equality rights are infringed by s. 241(b), and it may be granted by a superior court upon application if the stated conditions, or similar conditions tailored to meet the circumstances of particular cases, are met.

*Per* Cory J. (dissenting): Substantially for the reasons given by Lamer C.J. and McLachlin J., s. 241(b) of the *Code* infringes ss. 7 and 15(1) of the *Charter* and is not justifiable under s. 1 of the *Charter*.

Section 7 of the *Charter*, which grants Canadians a constitutional right to life, liberty and the security of the person, is a provision which emphasizes the innate dignity of human existence. Dying is an integral part of living and, as a part of life, is entitled to the protection of s. 7. It follows that the right to die with dignity should be as well protected as is any other aspect of the right to life. State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity.

There is no difference between permitting a patient of sound mind to choose death with dignity by refusing treatment and permitting a patient of sound mind who is terminally ill to choose death with dignity by terminating life preserving treatment, even if, because of incapacity, that step has to be physically taken by another on her instructions. Nor is there any reason for failing to extend that same permission so that a terminally ill patient facing death may put an end to her life through the intermediary of another. Since the right to choose death is open to patients who are not physically handicapped, there is no reason for denying that choice to those that are. This choice for a terminally ill patient would be subject to conditions. With those conditions in place, s. 7 of the *Charter* can be applied to enable a court to grant the relief proposed by Lamer C.J.

Section 15(1) of the *Charter* can also be applied to grant the same relief at least to handicapped terminally ill patients.



**Nancy B. v. Hôtel-Dieu de Quebec et al Statement of facts reproduced from Nancy B. v. Hôtel-Dieu de Québec et al. 86 D.L.R. (4th) 385**

The plaintiff, age 25, had suffered for two and one-half years from Guillain-Barré syndrome, an incurable neurological disorder that left her incapable of movement. She could breathe only with the assistance of a respirator. With it she could live a long time; without it her life would be brief. Her intellectual capacity and mental competence were unaffected. To establish her right to refuse further treatment, including the continued use of the respirator, she commenced an action for an injunction against the hospital and her physician to require them to comply with her decision. The hospital entered an appearance but did not contest the claim. her physician did not appear. The judge, of his own motion, made the Attorney-General of Quebec a party. All parties were represented at the hearing. The Attorney-General filed an appearance and intervention.



*Held*, the plaintiff was entitled to the injunction sought. Permission should be given to her physician to cease treatment with the respirator at a time chosen by the plaintiff. The physician was entitled to the assistance of the hospital.

Use of a respirator to maintain life is a “treatment” and hence is something within the individual’s control. By arts. 19 and 19.1 of the *Civil Code of Lower Canada* the person is inviolable except with the person’s consent or legal authority, and no one need submit to any treatment, examination or other intervention. By virtue of the *Code of Ethics of Physicians*, R.R.Q. 1981, c. M-9, r. 4, arts. 2.02.01, 2.03.02 and 2.03.28, a person is entitled to autonomy in respect of his or her body. No treatment may be given to a person except with that person’s consent or that of someone authorized by law or mandate to give consent. A physician is obliged under the *Public Health Protection Act*, R.X.Q. 1977, c. P-35, to protect the health and well-being of an individual but may not interfere with the person’s free choice of a physician and must obtain the free and informed consent of the patient to any treatment.

The right of the individual to refuse treatment is almost absolute, being subject only to a corresponding right of others. The individual may not threaten the life or health of others. The individual has the right to determine whether or not to accept treatment and putting and keeping someone on a respirator and without an informed consent is an improper interference with the person.

The *Criminal Code*, R.S.C. 1985, c. C-46, does not affect the case. The plaintiff’s death would be natural and would not involve homicide or suicide.



**R. v. Brush Between Her Majesty the Queen, and Jean Brush [1995] O.J. No. 656 Ontario Court of Justice (Provincial Division) Hamilton, Ontario Zabel Prov. J. March 2, 1995.**

CHARGE: On February 13th, 1995, Jean Brush pleaded guilty to the following charge: “that on or about the 18th day of August, 1994, at the City of Hamilton in the said Region, did unlawfully kill Cecil Brush and thereby committed manslaughter, contrary to the provisions of section 234 of the *Criminal Code*.”

In imposing sentence today, I have considered numerous factors including the tragic circumstances leading up to the events of August 18th, 1994. Jean Brush was born on January 20, 1914, and Cecil Brush was born on July 30, 1913. They were married on June 6, 1936. Mr. Brush was eighty-one at the time of his death and Mrs. Brush is presently eighty-one years of age.

The Brushes were married some fifty-eight years and have one daughter. Cecil Brush worked at Dofasco for forty-three years before his retirement in the early 70’s. They lived together for forty-three years in the same house in Stoney Creek. By all accounts they were a very happy and loving couple who were inseparable and enjoying their retirement years.

Unfortunately the health of Cecil Brush started to decline. His eyesight deteriorated; he was diagnosed as suffering from Alzheimer’s and consequential depression. Mrs. Brush found it increasingly difficult to deal with her husband who, as a result of his medical condition, was undergoing severe personality changes and suffering from hallucinations.

[...]

The traumatic change in the otherwise happy life at the Brush home is set out dramatically in the report of Doctor Bartolucci, a psychiatrist, which has been filed as an Exhibit in these proceedings. In part of his report the doctor states as follows:

[...]

They had a conversation about both of them dying together and this was after this first admission. He had been imploring her to do something but in the course of the conversation he told her that he would just like to go to sleep and not wake up again.”

“There were eight sleeping pills within reach and she asked him if he wanted to take them and he did. Mrs. Brush felt that she should follow him and she took twenty-eight sleeping pills plus some whiskey since she believed that the liquor would enhance the effect of the pills. She and her husband lay down and she woke up in hospital where she learned to her relief that at that time that she had not survived alone, that her husband also survived.”

It became apparent from the facts presented to me that both Jean and Cecil Brush were becoming increasingly despondent over the deterioration of Cecil Brush. As a result she had lost a considerable amount of weight prior to July, 1994, because of the increased care that her husband required and the depression they both felt as a result of his condition.

In June of 1994 Cecil Brush was admitted to the Stoney Creek Life Care Retirement Centre for one week but was discharged to the care of his wife at their home in Stoney Creek. On August 3rd, 1994, Cecil Brush was placed in the Clarion Nursing Home in Stoney Creek for a period of one month. During that period of time efforts were being made to find a more permanent home for Mr. Brush.

On August 18th, 1994, at approximately 11:15 a.m. Jean Brush arrived at the nursing home and signed her husband out for lunch. He was to return by 2:00 p.m. that day. Neighbours at the Brush home would indicate that Jean and Cecil Brush were seen to arrive home at around noon on August 18th, 1994.

Shortly after 5:00 p.m. their daughter, Joan Myers, arrived at their home after work. She went upstairs to find her mother and father lying on blankets which had been placed on the floor in the dining room. She immediately called for emergency help and the Fire Department, ambulance personnel and Police arrived shortly thereafter.

The first officer on the scene arrived at approximately 5:20 p.m. He observed Mr. and Mrs. Brush on the floor in the dining room. Jean Brush was lying next to Cecil Brush and was holding his hand. The ambulance personnel were attending to Jean Brush at the time the officer first arrived. The officer noted that Cecil Brush had a large wound to the stomach area in the middle of his stomach just below the rib cage. His shirt had been rolled up just above the rib cage. It appeared to the officer that Cecil Brush has passed away but that Jean Brush was still breathing and was receiving medical care.

[...]

Jean Brush admitted to the Police that she had stabbed Cecil Brush and herself and identified the knife that she had used. According to Defence counsel, Mrs. Brush’s evidence at trial would have been that she got the knife and that her husband had his hand on the knife and that he stuck it in himself but was not successful and that she then manoeuvred the knife so the fatal wounds could be inflicted. She had stabbed herself five times in the abdomen and was transported to General Hospital to be treated for her wounds. Her wounds were not considered to be life threatening.

The suicide note which was found was filed as an Exhibit and reads as follows — the note was from a journal that Jean Brush kept and the entry referred to is dated the date of Cecil Brush’s death being August 18, 1994, and I quote:

“Cec’s and my situation is getting worse day by day and will not get better. Cec being blind and with Alzheimer’s disease is like being in a nightmarish hell. We have lived our lifetime and it must end before we

become vegetables. Medical profession and Governments won't do anything to use euthanasia or mercy killing to put suffering elderly people out of the torture and agony that they are in."

"People in nursing homes, the people in psychiatric wards, mentally and physically dead but breathing and they are kept alive as long as possible. Why? Why? Handicapped children, extremely handicapped in mental incapacities and physical incapacities kept alive but not living per se."

"Do the medical profession and Governments care what effect this has on the families? It doesn't seem like it."

"Joan's life is being disrupted and it will get worse for her and that sacrifice shouldn't be asked of anyone. Families have their own lives to consider. Life for the young must go on."

"Cec as he was, young, vibrant, full of life is no more. He is a shell, dead but not buried because he still breathes."

"Darling Joan: No matter how it happens, it's going to be a shock. I can't let Dad suffer any more. I know I have to go also. I transferred Dad's small account to the joint account but Dana Kelly needs a copy of the Power of Attorney" — namely Dad's. "Would you take it to her when you have a chance and time?"

"We love you and Karen and Shawn and adding Michael to the family."

[...]

#### ANALYSIS:

Section 236 of the *Criminal Code* of Canada sets out the punishment for the crime of manslaughter as follows:

"Every one who commits manslaughter is guilty of an indictable offence and liable to imprisonment for life."

There is no minimum penalty set out for this offence and the sentences imposed by various courts have ranged from life imprisonment down to a suspended sentence in a small number of cases.

Defence counsel has urged this Court to impose a suspended sentence and Crown counsel has agreed that this type of sentence is within the appropriate range for these particular circumstances.

In reviewing the case law, I found a number of cases where suspended sentences were imposed but none of the cases referred by counsel or reviewed by me are similar to the facts of this case.

The courts have developed a number of principles of sentencing to assist them in imposing sentence and these principles of sentencing are general deterrence, individual deterrence, protection of the public and the offender's rehabilitation. The courts attempt to balance all these principles in arriving at an appropriate sentence.

The question now to be determined is: what is the appropriate sentence to be imposed in this case? Jean Brush is eighty-one years of age. She has been a contributing member of society all her life and has never had any involvement with the law. Because of circumstances which got out of her control, she now finds herself convicted of one of the most serious offences in our *Criminal Code*.



Her and her husband's cries for help were not answered and she became involved in what has been described as a mercy killing or euthanasia in a desperate attempt to end her and her husband's life with some shred of dignity and without becoming burdens on society.

The present state of law in Canada is that suicide is lawful but to assist a suicide is unlawful. The issue of assisted suicides has been addressed by the Supreme Court of Canada in the case of Rodriguez versus The Attorney-General of British Columbia.

[...]

There are compelling and thoughtful arguments on both sides of the euthanasia issue which cannot be resolved by the courts but must be left in Parliament's hands. It is up to the legislators to decide whether the present law should be changed so that someone in Mrs. Brush's position in the future will no longer face criminal sanctions.

SENTENCE: Considering the totality of everything presented to me, I find that in this case exceptional circumstances exist which justify the imposition of a non-custodial sentence. There is no doubt in my mind on what has been presented to me that imposing the most lenient sentence possible would serve the ends of justice and that Mrs. Brush remaining in the community would not endanger the safety of the community.

I can see no principle of sentencing which would cause me to incarcerate Jean Brush and perhaps shorten her life. She has already suffered a harsher sentence than could ever be imposed by this Court, the loss of her loving and devoted husband under these tragic circumstances and the trauma of becoming involved in a very public criminal prosecution at this stage of her life.

I will not compound this tragedy by incarcerating Jean Brush. Accordingly, I am suspending the passing of sentence and Jean Brush is placed on probation for a period of eighteen months. The probation order will contain the usual statutory terms and the following additional terms:

Firstly, she is to report forthwith as required to a probation officer and thereafter as the probation officer directs. As well she is to attend for all medical treatment as directed by the probation officer and abide by all directions as set out by her doctor.

[...]

That is the sentence of the Court unless there is anything else from counsel.



**Malette v. Shulman et al. Indexed as: Malette v. Shulman (Ont. C.A.) 72 O.R. (2d) 417 [1990] O.J.**

The plaintiff was severely injured in an automobile accident and was taken unconscious to the defendant hospital where she was examined by the defendant physician in the emergency department. He concluded that a blood transfusion was indicated but a nurse discovered a card in the plaintiff's purse identifying her as a Jehovah's Witness and requesting on the basis of her religious convictions that she be given no blood transfusion under any circumstances. Having formed the opinion that the plaintiff's condition made a blood transfusion necessary to preserve her life and health, the defendant physician personally administered transfusions to her and later refused to follow the instructions of the plaintiff's daughter who sought to terminate the transfusions. The physician believed that it was his professional responsibility to give his patient a transfusion and he was not satisfied that the card expressed her current view. The plaintiff recovered and

brought an action against the physician, the hospital, its executive director and four nurses, alleging that the administration of blood constituted negligence and assault and battery. The trial judge awarded the plaintiff \$20,000 by way of damages for battery. The defendants appealed to the Court of Appeal.

Held, the appeal should be dismissed.

The plaintiff had a right to control her own body. The tort of battery protects the interest in bodily security from unwanted physical interference. Any non-consensual touching which is harmful or offensive to a person's reasonable sense of dignity is actionable. A competent adult is generally entitled to reject a specific treatment or all treatment or to select an alternate form of treatment even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion it is the patient who has the final say on whether to undergo the treatment. While in an emergency the doctrine of necessity may protect the physician who acts without consent, the doctor is not free to disregard a patient's advance instructions. The plaintiff had conveyed her wishes in the only way possible.

While the interest of the state in protecting and preserving the lives and health of its citizens may override the individual's right to self-determination in order to eliminate a health threat to the community, it does not prevent a competent adult from refusing life-preserving medical treatment.

The fact that the physician had no opportunity to offer medical advice could not nullify instructions intended to cover any circumstances where advice was not possible. Any doubts about the validity of the card were not rationally founded on the evidence.

The cross-appeal against dismissal of the action against the hospital and the order with respect to costs should be dismissed.



### **In The Supreme Court Of Nova Scotia her Majesty The Queen against Cheryl Mae Myers And Michael William Power**

FOR the purpose of Section 655 of the *Criminal Code* the following is an agreed statement of facts:

1. Mr. Layton Myers was born on August 14th 1925. He was married to Rita Myers on January 13, 1947. They had three children, Gary, Danny and Cheryl. Cheryl is the youngest.

2. In January of 1991 Rita Myers had a recurrence of liver cancer and she suffered for many months before dying. She was hospitalized prior to her death.

She was put on life support systems. Mr. Layton Myers, who had worked as a longshoreman for 36 years stopped working when his wife was first diagnosed with cancer in order to stay at home with her.

3. On August 1, 1991, after consultation with Rita Myers' doctor, Layton Myers and Cheryl Myers decided to take Rita off life support systems. Rita died that same day.

4. During the course of Rita Myers' illness, Ms. Myers spent a great deal of time with her father. During that time, Layton Myers told Ms. Myers that if he were to become ill like Rita he did not want to suffer in the way she did. He wanted to maintain his dignity.



5. Cheryl Myers is 36 years old. She left high school before completing grade eleven. She worked with the government for five years and then left to take upgrading courses. She became a single mother when she gave birth to her first child, Candice, who is now ten years old. Mr. Michael Power is 35 years old with a high school education and a community college course in aircraft maintenance taken in Moncton, New Brunswick. He married at the age of 19 and had two children Matthew who is 11 and Madonna who is 16. He separated from his wife, 11 years ago and the divorce was finalized three years ago. Mr. Power has sole custody of both the children and has raised Matthew since he was a baby.

6. Michael Power and Cheryl Myers met in October of 1990 and started living together soon thereafter. Cheryl Myers became pregnant with their child while nursing Rita through her illness and gave birth to Jessica on February 25, 1992. At present Mr. Power and Ms. Myers live in a common-law relationship together with the four children at 127 Herring Cove Road, Armdale.

7. Prior to Rita Myers' death, Michael had a cordial relationship with her. Layton Myers was a very private individual. After Rita died Mr. Power and Layton Myers became close.

8. Around December of 1992 Mr. Myers began to complain of a sore back. At that time he suffered a bad fall. Ms. Myers and Mr. Power convinced him to see his family doctor, Dr. Ernie Johnson. Mr. Myers had tests at Camphill Hospital and was diagnosed as having lung cancer. At that time he was given three months to live. Ms. Myers and Mr. Power met with the doctors and Mr. Power advised Mr. Myers about this prognosis. Mr. Myers was offered chemotherapy treatment but refused since it would not improve the quality of his remaining life.

9. After receiving confirmation of this diagnosis Ms. Myers moved in with her father at 20 Margate Drive in order to care for him. Mr. Power handled the household chores and went over to Layton Myers' house daily to spend time with him. It would have been possible to obtain a caregiver through Veteran Affairs but Mr. Myers, Cheryl Myers and Mr. Power decided that Ms. Myers and Mr. Power would deal with the matter themselves. Layton Myers felt most comfortable with Ms. Myers and Mr. Power. After Layton Myers refused chemotherapy he told Ms. Myers that he did not want to go into the hospital and die as Rita had. He wished to remain at home. He explained to Ms. Myers that he did not want to get to the point where he could not function for himself or have to wear adult diapers. Ms. Myers told her father that she would not let things go that far and that she would take care of him. Mr. Power reportedly was present during this exchange and participated in it.

10. Over the next several months Mr. Myers' health began to fail. Ms. Myers and Mr. Power had to help him to the bathroom and prepare special foods that Mr. Myers was able to digest properly. Mr. Myers lost considerable weight. He was being heavily medicated and he slept a great deal.

11. During this time Mr. Myers again told Ms. Myers and Mr. Power that his wish was to die at home. He asked them to help him die when he could no longer function on his own. Ms. Myers and Mr. Power agreed, though they continued to hold out hope that Mr. Myers would somehow rebound from his condition.

12. During the police investigation of this case a relative of Ms. Myers, a cousin, came forward and indicated to the police in a statement that Mr. Myers had clearly expressed a wish to die to him as well.

13. In April, 1993, Mr. Myers' condition was very bad. He was almost constantly confined to bed. It became necessary for him to use adult diapers as he had lost control of his bodily functions. Mr. Power frequently helped to change those diapers. Mr. Myers was very uncomfortable and embarrassed as a result of the loss of control of his bodily functions and the consequent loss of dignity.

14. Ms. Myers bathed and shaved her father regularly. She provided quality care.

15. Mr. Myers' continued loss of bodily control eventually left Ms. Myers no longer physically or emotionally able to provide primary care to Mr. Myers without assistance. Mr. Power moved into Mr. Myers' house leaving his eldest daughter in charge of the young household. Mr. Power and Mr. Myers spent considerable time together. Mr. Myers' condition worsened daily.

16. By Friday, May 14, 1993, Mr. Myers had reached the point where his breathing was laboured and he was in great pain. Mr. Myers had not eaten since May 11, 1993. That morning would be the last time he recognized Ms. Myers or spoke with Mr. Power, as that was the last day he was conscious.

17. On Saturday morning May 15, 1993, Mr. Myers was unconscious and in intense pain.. Ms. Myers and Mr. Power called Dr. Johnson who was out of town so Dr. Norman Pinsky, who was on call, arrived at Mr. Myers' residence. Dr. Pinsky advised Ms. Myers and Mr. Power that Mr. Myers death was imminent, likely within one or two days at the most. At this point Ms. Myers and Mr. Power knew that all hope for Mr. Myers' survival was gone.

18. Mr. Myers was receiving large doses of morphine to control pain, but it seemed from his breathing that he was regularly experiencing considerable pain.

19. As requested, Dr. Pinsky returned to the Myers' residence later on May 15, 1993. At that time Layton Myers was feverish, his breathing was very laboured and irregular. He was still unconscious. Dr. Pinsky advised Ms. Myers and Mr. Power that he believed Mr. Myers would die very shortly, within hours or that night.

20. Ms. Myers and Mr. Powers discussed their earlier decision not to allow Mr. Myers to continue suffering.

21. Ms. Myers cleaned and shaved her father. She dressed him. At this time, Ms. Myers and Mr. Power placed a pillow over Mr. Myers' face and suffocated him. Ms. Myers then called a funeral home and requested the minister to come to the Myers' residence.

22. Dr. Pinsky signed the Death Certificate and Mr. Myers was buried in the normal course. No autopsy was performed on Mr. Myers as death had been expected.

23. Ms. Myers and Mr. Power did not attempt to make a secret of what they had done. On more than one occasion Ms. Myers advised members of her family of what she had done and why. These people were not favourably disposed to her when she made these revelations. Ms. Myers and Mr. Power also openly advised friends, on more than one occasion, that they had ended Mr. Myers' life and why they had done so. It was in this way that the police found out what had occurred and charges were eventually laid.



**Ontario Court (General Division) Her Majesty The Queen against Alberto De La Rocha  
Reasons For Sentencing Of The Honourable Mr. Justice S. Loukidelis In Timmins Ontario  
On The 2nd Day Of April, 1993.**

The accused stands charged in a two count indictment. Under the first count he was charged with second degree murder and on the second at the same time and place he was charged with administering to Mary Graham a noxious thing, to wit: an injection of 40 mg of morphine and 20 milliequivalents of potassium chloride, with intent thereby to end her life. The accused entered a plea of guilty to the second count and the first count of the indictment was indeed withdrawn.

Following and during the submissions of counsel for the accused, the matter was discussed both in court and between counsel concerning an amendment to count two. The plea was struck and the second count was amended and the accused was arraigned and entered a plea with the evidence theretofore heard having been taken as having been heard in the trial of the amended count.

The court has been assisted by an agreed statement of facts that was read in by the police investigating officer. In addition the court was told that immediately after paragraph 13 there was a notation in the notes in the hospital records of an observation made of the deceased at 8:20 p.m. and that indicated a deterioration from the deceased's situation as described in paragraphs 13 and 14. While that piece of evidence was submitted by counsel for the accused, counsel for the Crown agreed.

The accused comes before the court without a previous record. I have been urged to consider the principles of sentencing and indeed those have been stated by counsel. These are both particular and general deterrence, the protection of society, and the rehabilitation of the accused person.

[...]

In looking at the submissions of both counsel and their views on the principles of sentencing, counsel for the Crown was not in disagreement with counsel for the accused, that specific deterrence and rehabilitation were not issues in this trial. The sole consideration where the issue was joined is on the question of general deterrence.

Before dealing with those principles, I want to make some reference to the statement of facts to put in context the situation with which the family of the deceased and the doctor were faced on the 15th October in 1991.

Mrs. Graham had not been well. She had seen her doctor and at the end of August 1991 her family doctor had noticed a lump on the neck of Mrs. Graham. By September 24 that lump was conjoined with complaints by Mrs. Graham of difficulty in swallowing and she was sent to a specialist in internal medicine, who then not only noticed by October 7 of that year that the neck mass had increased, but that Mrs. Graham was in some distress. The appointment with Dr. Adesanya was advanced and he saw Mrs. Graham on October 8.

There was a need of surgical biopsy and Dr. de la Rocha was called in. He saw her on October 9, reviewed the X-rays, and made a preliminary diagnosis that there were two masses there and that it would be necessary to make arrangements for a biopsy. He wanted to refer this patient to expert care in Toronto or Sudbury.

She was admitted to hospital on the 14th of October with the biopsy scheduled to take place on the 15th. She arrived on her own without apparent difficulty.

It was during the biopsy that there were difficulties noted. Dr. Gaida, who was a specialist in anesthesiology and who was to be the anesthetist noted that she had experienced respiratory problems when she was asked to lie down. He noticed that she was cyanosed with partial airway obstruction. It was decided to advance the biopsy.



It was during that procedure that her respiratory difficulties were noted and it was considered necessary to intubate her. Dr. Hook, an anesthetist who was on call at that time, was there and assisted. She was in great distress. Her condition from the examination that preceded the biopsy indicated not only a tumour on the tongue, but a very large tumour in the bronchial area that had occluded one bronchus and on the other it was 50% occluded.

With the ventilator there were problems and it was then that the nurse was requested by Mrs. Graham that she wanted the tube removed. She received that message by reading her lips because presumably with the tube in her mouth she would have had difficulty speaking.

[...]

While not expected to survive the night, at least in the mind of Dr. Hook, she did survive. It was to nurse Cooper that Mrs. Graham gave some cause for alarm. She did not seem to be responsive to normal neurological assessment. She did not answer to her name, did not open her eyes, and did not move in response to pain stimuli.

Subsequently, at 9:30 in the morning, Dr. de la Rocha attended and Mr. George Graham, who had arrived from Sudbury, indicated that he wanted his mother kept alive until the other brother in Burlington, Dr. Jamie Graham, could attend.

We have a situation where the tube is taken out, at her request. The patient knew that she would die. She was told that - - and she had understood that with the removal of the tube that her life had been foreshortened by her own insistence, that the extubation procedure be completed.

Dr. de la Rocha removed the tube and he requested that lots of morphine be supplied. He administered 20 mg of morphine that had been supplied by nurse Janet Donaldson. It was noted that even after extubation (which took approximately 30 seconds — the family was around) Mrs. Graham breathed on her own and normally, although she had assistance of a Puritan mask that supplied 50% oxygen.

He administered the first 10 mg morphine with a second 10 mg, and then a second 20 mg was given. It is not entirely clear from paragraph 29 whether there was a stoppage of breathing after the 40 mg or between the administration of the first and second administrations of morphine, because paragraph 29 tells me, "Dr. de la Rocha administered the said dosage and by this time the patient had stopped breathing with the heart rate dropping to the 50s." It was at that point that the accused asked for potassium chloride from the unit and the nurse had not only advised him that there was potassium chloride in the unit, but she would not get it for him. The doctor proceeded to get it and administer it himself.

We do not know whether at that particular time she was breathing. We do know that once the potassium chloride was administered, death followed rapidly with an episode of ventricular fibrillation, and that they called ventricular tachycardia.

[...]

In my view, if it were the advancement of the claim that a medical doctor can administer a lethal dosage of a drug or substance in order to kill a patient for the purposes of euthanasia, in my view that is a breach of the law and is deserving of severe punishment — not only severe punishment by sanctions (as suggested by the Crown) but should be attended with a long period of imprisonment.

[...]

Until the law is changed, people must obey the law. No one can be held to be above the law in these circumstances, having said that, I am not convinced from the passages that I see that that advance of the claim



of euthanasia was in the mind of the doctor when he administered the bolus of potassium chloride. The evidence that establishes for me that the 20 mg of morphine was not a lethal dose — and even the 40 mg in the face of the testimony of Dr. Meloff and others who were questioned in respect to that — did not mean that death would result. At the same time we do know that after 20 mg, or perhaps even after 40 mg her breathing had stopped and her heart rate had fallen to the 50s. She was still alive, but without her breathing it would clearly indicate that death was not a matter of hours or days away, but perhaps seconds or minutes. Under those circumstances it would seem to me that the potassium chloride in those circumstances was administered to a patient who had already stopped breathing.

The question in my mind is what is the appropriate penalty. I take it that general deterrence does play a part here and must play a part in offences of this kind. I take it as a principle that while a first offender ought not to go to jail, there are times when a first offender must go to jail because the offence is a serious one. Here the offence is one of administering a noxious substance.

I take into consideration a number of factors that I have found eloquent testimonials, that is the evidence of not only two of his colleagues and one nurse and one patient who gave evidence today, but the 53 letters that were entered as exhibits four and five respectively. What they show to me is a person of good training, excellent skills, a person who has held his patients first in his professional life. He was prepared at a moment's notice to go in. Many of his patients spoke of the care that he took in explaining to them their illness. His colleagues, both nurses and doctors, not only spoke of his training but his ability to take decisive and quick action to look after his patients with positive benefit to patients. Because of that ability he could conscript or marshall his skills very quickly to meet on-coming emergencies. That talent for decisive action is one of the strong points that came out in these letters.

There is no doubt that he is highly regarded in his profession. He is highly regarded by paramedicals and by the hospital personnel who have worked with him. There is no doubt in my mind that he understands the high calling to which he has been summoned to practice medicine. This is seen in the way he has worked for the benefit of his patients. All of those factors tell me that he has tried to exercise his skills in a positive way.

At the same time it seems to me that in his handling of this particular matter, he took swift action and he took action that brought him into breach of the criminal law. He obviously didn't take or hear the refusal of the nurse to supply him with the potassium chloride seriously because he himself went immediately to get it. He didn't stop to consider that he was passing from palliative treatment in the administration of the morphine to an action that would bring immediate death to Mrs. Graham. At the same time, at least on the facts to which counsel agreed that I should act show that by the time the morphine was administered, whether one half the total that he gave or all of it, she had stopped breathing.

[...]

Even where the maximum penalty for manslaughter is life imprisonment, a person who commits that offence may well not be incarcerated depending on the facts and circumstances. This was particularly true as well in the decision of *R. v Hardy*, the case of *Barrette Joncas, J.* where a husband was given a suspended sentence at the request, and with the approbation of the sisters and the mother of the deceased person. In reading the facts of that case, one cannot help but see the poignant choices that the deceased's family had to make in relation to that particular fact circumstances.

[...]

Indeed there are fact circumstances that make this case different from Mr. Mattaya's case. Here was young man, 25, who had only been a registered nurse for a year or a year and a half, and was faced with a patient who was on life support systems that had been withdrawn. He had been given double the dosage of morphine to that seen here and 60 mg of Valium and who began reacting in a way that in effect caused Mr. Mattaya to panic. At page 21 of the report, the reasons for Justice Wren, he said, "In the unique circumstances of this

particular case, in my opinion a sentence must be sufficient to serve the purposes of general deterrence to avert as much as possible by the court acting on behalf of the interests of society the ever present danger of individuals taking into their own hands the right over life and death. The precious nature of life must take foremost consideration in such circumstances. In these unusual circumstances I am of the opinion that a sanction of incarceration is not required to meet these ends.”

In looking at that passage I cannot help but be persuaded that in serving the purposes of general deterrence, and my role in acting on behalf of the interests of society, that it is not necessary in these circumstances to order a period of incarceration. As I say, the result may well have been different were I persuaded that this was a case where the accused was relying on the excuse or justification that he was doing this because he believed in euthanasia. It is true that he said that in that paragraph. As I say, I am not convinced that it was not anything more than a retrospective, post-mortem expression of views on the matter.

I also have to take into consideration the views of the family. We seek victim impact statements. We also seek the views of a victim’s family. In this case I was moved by the evidence of George Graham. He spoke clearly and to the point on this issue. There is no doubt that he and his brothers have discussed the very issues that were put to him in the questions that were asked. He does not see incarceration as the answer, and I do not think that he was moved by anything but a charitable response to the difficulties in which the doctor has found himself. To me those views of the family have been very important in the conclusion to which I have come.

Having concluded that there should be no incarceration, the next question I must ask myself is what the result should be. In my view there should be a suspended sentence with a period of probation of three years. I append only one condition, that he keep the peace and be of good behaviour.

I have been concerned about the request that I make it a condition of the probation that he not be allowed to practice medicine. That has concerned me over the past few days because I saw that as a possible alternative. But I have come to the conclusion that the interests of justice and the principles of general deterrence will not be advanced by the imposition of a penalty of this kind.

The accused now has a criminal record. He has to face his peers and he also has to know that the principles of life are not excepted for people who face overwhelming disease and are at the point of death’s door.

Accordingly I am endorsing the following:

Conviction entered. Sentence suspended. Accused is placed on probation for three years on conditions a) he keep the peace and be of good behaviour.

I should point out to you, Dr. de la Rocha, that where a person has been placed on probation and sentence has been suspended, you must understand that should you breach the terms or condition of your probation, and in the event that you commit a criminal offence and you have been convicted or either one or the other, that you can be brought back before me to be sentenced in relation to this offence, provided that you have not appealed that conviction, provided that you have appealed and the appeal has been dismissed, or you have withdrawn your appeal. That means that you would come back before me and be sentenced anew for this very offence if that were to be the case.



# Appendix M

## Palliative Care in Canada

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### 1. Introduction

The first palliative care programs were established in Montreal and Winnipeg hospitals in 1975. Four hundred and fifteen palliative care programs are now included in the 1994 directory of the Canadian Palliative Care Association. Canada has a reputation on the international scene for the development of hospital-based palliative care and for the quality of some of its palliative care professionals. However, many witnesses stated before the Committee that palliative care is still largely unavailable in Canada even in major cities,<sup>1</sup> although programs exist in every province.

The purpose of this appendix is to provide detailed information regarding palliative care services in Canada. We will briefly review the definition of palliative care, then analyze the position of palliative care services in the overall Canadian health care system, and describe the present situation in the provinces.

### 2. Definition of Palliative Care

The high degree of specialization of medicine, the perceived anonymity of care, the emphasis on acute care in hospitals, and a tendency to be preoccupied with curing illness over easing suffering, by attending to the total needs of the person, have made many seek alternative approaches:

There is an image of dying people that many Canadians have - the person is comatose, hooked up to monitors with intravenous tubes sticking out everywhere. We have too often seen our loved ones like this and we have seen them in pain and suffering.

Hospice care is different. It makes sure that someone is relatively free of pain, is often able to be awake so they can remain an active part of their families until a few hours or days before death, does not use monitor or tubes, and tries to give as much control to the patient and family as they choose to have<sup>2</sup>

Many witnesses referred to the Health and Welfare Canada definition of palliative care:

Palliative care is a program of active compassionate care PRIMARILY directed towards improving the quality of life for the dying. It is delivered by an interdisciplinary team that provides sensitive and skilled care to meet the physical, psycho-social and spiritual needs of both the patient and the family. The philosophy and principles of palliative care may

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1 "Is organized palliative care available throughout Canada? The answer to that question is a categorical "no" [...] also [that] it is not available in some major centres" (Latimer, 4:12). "There are very few people who receive appropriate palliative care services" (St-Germain, 9:23). "The number of patients who are dying who can receive palliative care is minuscule. If they have good hospice care, they do have pain control. We are concerned about the people who do not have palliative care" (Scandiffo, 8:48). "Palliative care in an organized and accessible form is available in any large urban centres in Canada [...] rural areas are the most difficult for service to be provided. The biggest problem has to do not so much with the quantity and placement of service as its connectedness or disconnectedness from other care" (Henteleff, 5:17). "This does not just apply to under-served areas. There are major centres where palliative care is not available to all of the people who require it" (McGregor, 4:53). "It is (palliative care) certainly not available in all communities, and especially in smaller communities; palliative care or, frankly, access to psychiatric resources, is difficult" (Rowand, 9:36).

2 Harry van Bommel, *Dying for Care - Hospice Care or Euthanasia*, NC Press, Toronto 1992, 24.



apply to patient population other than the dying and palliative care programs may have a SECONDARY role in addressing the needs of these populations (capitals in the text)<sup>3</sup>.

Others referred to the World Health Organization which :

Defines palliative care in terms of being active, total care, focusing on control of pain and other symptoms and [...] psychological, social, and spiritual support aimed to improve the quality of life [...] it affirms life and regards dying as a normal process; that it neither hastens nor postpones death.

*Mount, 5:30*

Palliative care associations promote integrated delivery services such as care and support to dying persons and their families through teams of professionals and volunteers; bereavement support to families; and public awareness and education.

A coordinated network of interdisciplinary services that provides active, compassionate care to the terminally ill at home, in hospital or other care facility [...] when quality of life rather than treatment directed at cure or prolongation of life is the primary objective. It is delivered by an interdisciplinary team that provides sensitive and skilled care to meet the needs of the whole person and to promote the on-going health of the family [...] the terminally ill person's friends and family play an invaluable part in the care [...] the care of the people who are dying is a responsibility shared by individuals and communities as well as social and health care systems.<sup>4</sup>

### 3. Canadian Palliative Care Associations

The Canadian Palliative Care Association (CPCA) was founded in 1991 and incorporated in 1993. It has a membership of some 250 individuals, provincial associations, and various programs and services organizations. VON Canada, the Canadian Cancer Society, the Canadian AIDS Society and the Canadian Society of Palliative Care Physicians are its four affiliate members. The CPCA receives financial support from Health Canada and it organizes national palliative care conferences every second year, publishes a Directory and promotes palliative care at the national level.

The typical provincial palliative care organization is registered as a charitable and non profit organization and is community-based. Nine out of ten were incorporated after 1990. They are advocates for palliative care policy development, adequate funding, the establishment of standards, and the development and expansion of palliative care services. They support palliative care groups and institutions by providing members education and development opportunities, networking, advocacy and informational services locally and nationally. They are financed through membership fees and charitable donations.

### 4. Availability of Palliative Care Programs

There is a dearth of published information on palliative care in Canada. Material has been provided by witnesses appearing before the Committee or gleaned from their briefs. Various governmental and non-governmental palliative organizations were asked to provide data. Articles are found in specialized journals, however, accurate statistical data is scarce about numbers of programs, institutions, number of patients, comparative costs, and other aspects of palliative care. Such material is not collected by Statistics Canada, the federal Department of Health or palliative care organizations.

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3 Health and Welfare Canada, Health Services and Promotion Branch, 1989, *Palliative Care Services, Report of the Subcommittee on Institutional Guidelines, Guidelines for Establishing Standards*, p. 1.

4 Island Hospice Association, The Prince Edward Island provincial palliative care organization, 1994, 12.

The 1994 *Canadian Directory of Services Palliative Care and HIV/AIDS* lists palliative care services for all provinces and territories. Table I summarizes this information and table II lists the number of provincial palliative care programs for 1981, 1986, 1990, and 1994. For example, there were 55 programs in Ontario in 1981, 11 programs in New Brunswick in 1990, etc.

TABLE I PALLIATIVE CARE PROGRAMS IN 1994*											
	TOTAL	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NFLD
<b>CLIENTELE</b>											
ADULTS	403	71	27	31	12	160	42	9	27	6	18
CHILDREN	247	46	19	22	2	102	17	7	19	4	9
CANCER	394	69	26	32	12	158	43	9	27	6	12
AIDS	302	59	21	16	8	131	22	8	23	4	10
OTHER	306	56	22	21	8	137	25	7	22	1	7
<b>AVAILABILITY</b>											
24 HOURS	245	48	19	27	6	79	30	7	7	4	18
OTHER	163	23	11	4	4	87	10	2	20	2	
<b>BEREAVEMENT</b>											
FOLLOW-UP	331	68	22	23	9	132	31	9	21	6	10
<b>TEAM</b>											
NURSES	290	51	25	29	10	85	42	2	24	7	15
PHYSICIANS	272	42	20	24	9	95	38	7	16	7	14
PASTORAL	238	35	18	19	8	86	36	6	11	6	13
SOCIAL WORKERS	216	35	14	21	9	77	26	6	12	2	14
VOLUNTEERS	336	81	23	20	14	115	37	7	25	7	7
PHYSIOTHERAPISTS	144	23	17	15	1	56	10	4	7	4	7
OCCUPATIONAL THERAPISTS	99	15	14	8	1	41	6	4	2	4	4
PSYCHOLOGISTS	47	5	4	2	0	14	18	1	0	1	2
PHARMACISTS	166	28	16	14	5	57	27	3	10	2	4
DIETITIANS	123	16	10	11	1	50	17	5	6	3	4
ED. COORDINATORS	74	17	3	4	4	25	11	1	5	1	3
OTHER	115	20	10	13	4	42	14	5	3	1	3
<b>IN-PATIENT SERVICES</b>											
ACUTE CARE	204	35	12	14	4	76	21	4	20	7	11
LONG-TERM	98	13	10	7	2	39	12	0	4	3	8
FREE STANDING	17	3	1	1	1	6	5	0	0	0	0
UNIT	87	21	2	2	1	31	19	2	1	3	5
SCATTERED BEDS	132	21	7	8	3	62	12	2	8	2	7
NUMBER OF BEDS	1301	168	49	21	37	567	378	20	22	26	13
<b>CONSULTATION SERVICES</b>											
YES/NO		40-22	12-4	17-5	5-3	95-33	32-9	6-0	15-4	4-2	5-8
CASE LOAD	7400	1585	260	403	504	3439	352	264	202	195	196

\*Compilation from Canadian Palliative Care Association, Palliative Care HIV/AIDS, Canadian Directory of Services.

TABLE II - PALLIATIVE CARE PROGRAMS IN THE PROVINCES - 1981, 1986, 1990, 1994

1. Province Name (Rank in 1981, 1986, 1990, 1994 for the Number of Programs for Each Year) 2. Rank in Population 1993; Population in 1993 (thousands) 3. Rank in Ratio Population(thousand)/Programs; Ratio Population(thousands/programs)	1981	1986	1990	1994
Ontario: (1) (1) (1) (1) 1 ⇔ 10,270.3 8 ⇔ 69.4	55	143	143	160
British Columbia (2) (2) (2) (2) 3 ⇔ 3,319.0 6 ⇔ 38.2	19	60	63	71
Quebec (5) (4) (3) (3) 2 ⇔ 6,970.8 12 ⇔ 122.3	9	39	41	42
Saskatchewan (3) (5) (6) (4) 7 ⇔ 1,008.4 4 ⇔ 30.6	13	20	18	31
Nova Scotia (7) (6) (5) (5) 6 ⇔ 910.8 5 ⇔ 30.4	4	17	20	27
Alberta (4) (3) (4) (6) 4 ⇔ 2,613.0 11 ⇔ 90.1	8	42	25	27
Newfoundland (6) (8) (9) (7) 9 ⇔ 575.9 3 ⇔ 30.3	5	9	8	18
Manitoba (7) (7) (8) (8) 5 ⇔ 1,112.9 10 ⇔ 92.7	4	12	10	12
New Brunswick (8) (7) (7) (9) 8 ⇔ 732.1 9 ⇔ 81.3	1	12	11	9
Prince Edward Island (9) (9) (10) (10) 10 ⇔ 133.1 2 ⇔ 16.6	0	4	5	6
Yukon (10) (10) (11) (11) 12 ⇔ 27.5 1 ⇔ 13.75	0	1	1	2
Northwest Territories (10) (11) (12) (12) 11 ⇔ 56.4 7 ⇔ 56.4	0	0	0	1
TOTAL	118	359	345	415

Sources: data for 1981 and 1986 from (Scott, 1992, 15); for 1990 from Canadian Palliative Care Association, 1990, *The Canadian Palliative Care Directory*; and for 1994 from Canadian Palliative Care Association, 1994, *Palliative Care and HIV/AIDS, Canadian Directory of Services*.  
Data for population from statistics Canada



Statistical information is provided in three different parentheses in the left column. In the first one, provinces are ranked according to the number of their programs for each year. In the middle one, provinces are ranked by size of population for 1993.<sup>5</sup> In the third one provinces are ranked by the number of clients per program in 1993.<sup>6</sup> For example, Ontario has constantly been first in the number of programs; it has the largest population, but is eighth for the number of clients per program. British Columbia has been consistently second for the number of programs; third for population, and sixth for clients per program.

Palliative care programs increased by 304.2% between 1981 and 1986 (from 118 programs to 359); decreased to 345 between 1986 and 1990 and increased to 432 or 125.2% between 1990 and 1994. Ontario and British Columbia have kept the two top ranks through these years.

The information provided in these directories is of limited use as they are “based on self-reporting of services.” Some services may not have been reported and some that are in the Directory may not qualify in the absence of verification. It is, therefore, hazardous to make comparisons between provinces. For example, statistics are provided but there is no indication whether they represent a week, a month or, the whole year so that the number of cases may vary dramatically.

The real extent of palliative care programs is not known at this time. The most quoted estimate is that less than five percent of dying people in Canada receive palliative care.<sup>7</sup> This information was first cited in the *Canadian Palliative Care Directory* published in Toronto in 1987 by the Palliative Care Foundation from data collected in 1986.<sup>8</sup>

## 5. Palliative Care in the Canadian Health Care System

To properly delineate the place of palliative care services in the Canadian health care system, we must define the involved jurisdictions and applicable standards and differentiate these services from long-term care. We also must examine issues in their development (such as funding for activities and training of health care professionals).

### 5.1 Jurisdiction

According to the *Constitution Act* and its subsequent interpretation health is a provincial jurisdiction in Canada.<sup>9</sup> In practice, responsibility is shared with the federal government. The *Canada Health Act* defines basic principles. To summarize: “the federal government has [...] the financial resources to provide funding for health services but not the jurisdiction. The provinces have the jurisdiction but do not have sufficient financial resources to do what they choose”<sup>10</sup> The federal government affects health services through activities

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5 The year 1993 has been chosen to facilitate comparison with the number of programs in 1994 (data are collected the year before publication).

6 The first place is given to the lowest number of thousand of clients per program.

7 “Harry van Bommel’s book, published less than a year ago, includes his survey of the situation which indicates that five per cent of patients who request palliative care have it available to them” (Ms. Seguin, 7:40). “Only five per cent of dying patients in Canada receive palliative care” (Mount, 5:30-31) “In their book, *Health Care in Canada: A Description and Analysis of Canadian Health Services*, (1988, 1990), Dr. Ralph Sutherland and Professor Jane Fulton estimated that about 5% of people who are dying receive some form of palliative care service” (van Bommel, 28:19). The full quotation is: “Dr. Ralph Sutherland and Jane Fulton estimate in their 1988 book, *Health Care in Canada*, that less than five percent of dying people in Canada receive palliative care through formal recognized palliative care programs. They further estimate that perhaps 10% of cancer patients may receive palliative care” (Harry van Bommel, *Dying For Care - Hospice Care or Euthanasia*, NC Press Toronto, 1992, 33. Finally, the Canadian Palliative Care Association has issued a release, in January 1995, stating that “only a tiny percentage of the population has access to palliative care services - about 5%”.

8 Scott, “More Money For Palliative Care?” *Journal of Palliative Care*, 1994, 16.

9 With some exceptions such as specific population (native people, military, federal prisoners, residents of the territories).

10 Anne Crichton and David Hsu, *The Canadian Health Care System: Its Funding and Organization*, 1990, 28.

by various departments and through its spending power. The federal government can also significantly impact on health delivery by way of legislation or changes to existing Acts or regulations.

## 5.2 Standards

There is no single standard for health care programs across Canada. While standards for medical practice are usually defined by medical associations, minimal standards for programs are usually derived from the philosophy and principles guiding an individual program and developed by various stakeholders such as hospital, professional associations, and governments.

In developing standards there is often a dynamic interplay between federal and provincial jurisdictions. The Canadian Council on Health Facilities Accreditation, the Department of Health, the Federal/Provincial Advisory Committee on Institutional and Medical Services<sup>11</sup> are major players. "Provincial jurisdiction is quite absolute, subject only to rights enshrined in the Charter of Rights and other components of our constitution, and to the exclusion of the limited areas of federal jurisdiction."<sup>12</sup> However, federal legislation ensures Canadians of minimal, universal, and portable national standards in the delivery of health care programs. For palliative care, the following quotation from the Vice President of the Manitoba Hospice Foundation describes the actual process:

Health is a provincial responsibility. Concerning the hospitals in this city (Winnipeg) with palliative care units, the boards of the hospitals control ultimately what goes on in those palliative care units; but accreditation of educational programs, accreditation of all the postgraduate training programs for physicians, both specialists and family physicians, is the responsibility of national bodies, of the Royal College of Physicians and Surgeons and the College of Family Physicians of Canada. That way, if our palliative care training programs and other things are looked at by national organizations, then you can ensure uniformity even though the primary responsibility for the health is at the provincial level.

*Kirk, 17:57*

The Medical Director of the Palliative Care Program at St. Boniface Hospital added the following when asked if there are standards to follow for developing palliative care:

The Canadian Palliative Care Association is presently developing standards but they have not been put in the presses yet. There is a newly formed Canadian Society of Palliative Care Physicians. The development of standards in that society is one of our mandates as well.

*Dudgeon, 17:56*

## 5.3 Palliative Care vs. Long-Term Care

Palliative care is recognized as part of a continuum of care and services the objective of which is to improve the quality of one's last days by lessening physical, psycho-social and spiritual pain for terminally ill patients or for patients no longer in need of therapeutic or curative care.

11 Its guidelines program dates back to 1972. "Guidelines are produced by expert working groups of health professionals, some of whom are government representatives. The final draft is reviewed and recommended by the Subcommittee (on Institutional Program Guidelines, composed of federal and provincial governments and professional representatives) for approval by the Advisory Committee" *Health and Welfare Canada, Health Services and Promotion Branch, 1989, Palliative Care Services, Report of the Subcommittee on Institutional Guidelines, Guidelines for Establishing Standards*, p. iv.

12 Sutherland and Fulton, *Health Care in Canada: A Description and Analysis of Canadian Health Services*, Ottawa, The Health Group, 1988, 54.

The continuum may begin with family care by a family physician, continue with acute care in an hospital setting, then move on to long-term care and to community care in a home or in a hospice.

Long-term care is part of the same continuum. It is defined by the Canadian Long-Term Care Association as: “an integrated mix of services devoted to respecting personal autonomy, maintaining or promoting health or restoration, and providing social and personal supports as required.”<sup>13</sup>

Long-term care is delivered “for sustained periods of time either on a continuous or intermittent basis”<sup>14</sup> while palliative care is typically aimed at terminally ill patients. The average stay in palliative care services is very low: 19 days in the Maison Michel Sarrazin in Quebec City<sup>15</sup> and the median at Elizabeth-Bruyère Care Centre in Ottawa is between 15 and 21 days.<sup>16</sup>

Dr. Wyman, in his testimony, quoted the administrative definition of palliative care services used by the Ontario Medical Association:

As it currently stands, the palliative care fee applies to one designated physician responsible for the care of a terminally ill patient suffering from disease. Palliative care will be deemed to start when care is directed to maintaining the comfort and emotional well-being of the patient and the non-aggressive treatment of the underlying disease process. Palliative care fees should be charged retroactively after death on the basis of actual visits rendered for a period not to exceed four weeks prior to death and are not meant to apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death. That last part was intended to ensure that if somebody was in hospital with a chronic illness and then died of some other cause, that palliative care was not being applied in those circumstances because it was not an expected death for a terminal disease.

*Wyman, 20: 72-73*

Some proponents of palliative care envision a “seamless” system where services are offered much earlier and patients do not have to relocate to receive appropriate care.

It is difficult to precisely delineate when one type of care begins and when the other finishes. Both offer community-based services and services “in nursing homes, homes for the aged, special care homes and extended care health centres”<sup>17</sup> The Ontario Palliative Care Association, in a brief concerning Ontario Bill 173, stated:

We believe palliative care is an essential part of long-term care. [...] We believe long-term care facilities, including chronic care beds, have an important role to play in the provision of palliative care. [...] In conclusion, the Association supports the redirection of long-term care ensuring patient/client centered care for the terminally ill.<sup>18</sup>

The blending of long-term and palliative care is encouraged by the shift of care in provinces from institutions to community-centred care and home care. Many long-term care services have palliative related components in them.

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13 Brochure, Canadian Long-Term Care Association.

14 *Ibid.*

15 Dionne, 13:16.

16 Interview with Dr. John F. Scott, Director of the Elizabeth-Bruyère Care Centre, December 7, 1994.

17 Brochure, Canadian Long-Term Care Association.



## 6. Funding for Palliative Care

Health care is in a state of flux in Canada making it difficult to collect reliable facts on palliative care services and to expect that they will remain constant for very long. Large deficits have propelled provincial governments into reducing health spending. Health services are pressured to innovate to become more efficient. There is also a trend from hospitalization to community-based care.

In hospitals there is fierce competition by:

Medical specialists for scarce resources, most are anxious to introduce the latest technological advances in their specialty and all are curbed by hospitals budgets [...] the introduction of new techniques to improve life threatening conditions (such as heart disease or kidney failure) may take precedence over other repair technologies such as joint replacements, which are not necessarily to prolong life itself but will remove pain and improve the quality of life.<sup>19</sup>

Currently, physicians are linked to hospitals and are paid on a fee-for-service structure<sup>20</sup> This system has been identified as one factor in health expenditures is rising significantly higher than the overall population increase<sup>21</sup> Witnesses<sup>22</sup> have identified this form of payment as an obstacle to the development of palliative care, since it severely limits the time available to patients.

The situation is evolving. New Brunswick has innovated in setting up the New Brunswick Extra Mural Hospital which employs a professional medical staff. It is designed as a substitute to institutionalization, and an umbrella to provide for home care programs (see provincial section). A greater interest in preventive medicine has emerged; provinces are integrating some forms of community-based systems into their health care systems, and are creating regional structures for planning and delivering health services<sup>23</sup> Palliative care is more and more considered as an alternative to often excessively costly acute institutionalized care by provinces. At least four provinces have issued policy statements on palliative care, including Nova Scotia in 1988; Ontario in 1993, Alberta in 1993, and Saskatchewan in 1994).

## 7. The Health Care Crisis

In the 1990s certain aspect of the Canadian health care system are being questioned, including:

Centralized and rigid management, emphasis on curative and institutional care, number of physicians, their work practices, the fee-for-service pay system, and their monopoly on health services distribution; institutionalization and hospital practices, pharmaceutical

18 Fax, Ontario Palliative Care Association, August 16, 1994.

19 Anne Crichton and David Hsu, *Canada's Health Care System: Its Funding and Organization*, Canadian Hospital Association Press, 1990, 86.

20 Approximately 75% of physicians in the 1980s; the rest were salaried. Salaried physicians were "researchers and teachers; diagnostic specialists, anesthesiologists or medical administrators; public health specialists and specialists in occupational medicine." Usually the medical associations determine a fee schedule annually, to be negotiated with their respective provinces. However, some specialists, such as psychiatrists, are paid by sessions, others (pathologists, radiologists) are usually employed by hospitals (Crichton, 1990, 69).

21 Crichton, 1990, 121; Lamarche, "The Crisis of Health Services in Canada" 1994, 12.

22 "The position of the College of Family Physicians of Canada is not so much for more funding, but for better distribution ... We believe that the fee-for-service system does not reward family physicians appropriately for the type of care they provide best, including palliative care" (Dr. Perkin, 23:10). "The other specific area that I was requested to comment on was the payment mechanism for palliative care in Ontario. In the mid 1980s, it became apparent to the tariff committee that we did not have appropriate fees to pay for the services of the growing number of physicians providing palliative care." (Dr. Wyman, 20:72).

23 A number of reports have been published including: Nova Scotia, 1990, *Health Strategy for the Nineties*. British Columbia, 1991, *Report of The Royal Commission on Health Care and Costs*.





However, others doubted that palliative care services are necessarily cheaper. Dr. Elizabeth Latimer of Hamilton Civic Hospital declared that palliative care:

may be a little cheaper than high-tech health care, but we do not think we would want it to be that way because it requires a professional team of people [...] It will cost money [...] palliative care of intensely sick, dying patients at home may not be any less expensive than hospital care.

*Latimer, 4:15, 4:21*

The Director of Bioethics at the Hospital for Sick Children in Toronto reiterates that it is hands-on, not high-tech; it takes more people. (Lynch, 11:27). The President of Wellesley Hospital in Toronto added :

there is evidence that home care in some circumstances can be more expensive than institutional care. I think that is a reality. Very often, home care is sold on the basis of a cost-effective alternative to institutionalization. Sometimes it is; sometimes it is not.

*Rowand 9:44*

The Executive Director of Maison Michel Sarrazin continues:

in general, palliative care costs about half what hospital care costs. It makes economic sense. Dying at home, which is increasingly the trend, is still less costly. But community participation in the form of volunteers makes an extraordinary difference. I mentioned our 250 volunteers. If we had to pay all the people who work at Maison Michel Sarrazin, it would cost us the same as in a hospital.

*Dionne, 13:18*

However, there is virtually no comparative data and there is a lack of comprehensive studies. The only studies actually cited were two in the United States and an unspecific reference to some data published in Ontario in 1988.

Another approach to the issue of cost is to consider that the last year of life in cancer patients may represent 75% of the total health care costs of their lifetime,<sup>28</sup> and the claim that 25% of all hospital costs are spent in a patient's last month of life<sup>29</sup>. Costs are high because futile, aggressive and onerous treatments are used to keep the patient alive although some of these treatments may appear rather inappropriate for a dying person and even unethical according to some witnesses. They said that intensive invasive care caused increase in the chance of surviving.

A study done in Quebec in 1975-1976 led to the establishment of the Royal Victoria Palliative Care Unit in Montreal. At that time, palliative care unit hospitalization cost was deemed comparable to an acute care unit. Direct nursing personnel costs were slightly higher but that was compensated by significant savings from proper symptom control and, to a minor extent, by less expensive medication costs. Perhaps that study should be revisited to compare with actual experience over the years. But what is factual for one institution may not be valid for another.

Finally, some witnesses appeared pessimistic that palliative care can be made available while relying on volunteers and public and that it is difficult to innovate within the existing health care system.<sup>30</sup> However,

28 *Oxford Textbook of Palliative Medicine*, 761.

29 J. F. Fries, "Reduction of National Morbidity," in *Aging and Health: Linking Research and Public Policy*

30 "We must learn to better distribute our resources in health care [...] 90 per cent of our money are spent in large, acute care hospitals. That is great, but it means that people in chronic care, palliative care, and outreach into the community, are poorly supported" (Senn, 9:17).

most witnesses consider that the issues surrounding palliative care are more important than simple dollars and cents<sup>31</sup>.

## **9. The Training of Health Care Professionals**

Successful palliative care requires trained health care professionals. According to an inquiry by Dr. Neil Macdonald<sup>32</sup> none of the 16 Canadian faculties of medicine offers a formal palliative care course, although designated lectures within other courses are available to medical students<sup>33</sup>. Only two schools of medicine stated that they have a “definite commitment to increased curriculum time”. There are only 18.25 person years devoted to palliative care physician positions in Canadian universities. Dr. Macdonald, considering the lack of attention to palliative care, asks the question: “Why have not the principles of pain management and palliative medicine more clearly informed medical practice? His answer:

Part of the reason for this gap is what is taught and what is practised relates to the continued isolation of many palliative care programs from the mainstream of medical care [...] most of them are still concerned with a select group of patients, generally with cancer, toward the end of their life [...] palliative care should be more closely integrated into overall disease control programs. Using cancer as an example we may look upon cancer control as having four phases. 1. Prevention of occurrence (example - anti-smoking programs). 2. Prevention of invasive cancer (example - PAP tests). 3. Prevention of death or severe morbidity (surgery, radiotherapy, chemotherapy). 4. Prevention of suffering [...] Palliative care is [only] concerned with the fourth phase.<sup>34</sup>

Another reason advanced by Dr. Macdonald is the view which is not uncommon in academic circles today that palliative research and education may be regarded as “soft” and lacking in intellectual rigor. Palliative care, he says, struggles for academic recognition: many of its practitioners are not connected with academic centres and it lacks an international communications system.

## **Palliative Care in the Provinces**

### **BRITISH COLUMBIA**

“Palliative care is a core health service that each community or region must provide”, according to Paul Ramsay, Minister of Health, in a letter to the Committee in 1994. Mr. Ramsay said that since 1992, significant new funding has been allocated to palliative care/hospice programs to increase availability of services, train caregivers and volunteers, and develop educational and resource material. These had been among recommendations of the 1991 Report of the British Columbia Royal Commission on Health Care and Costs.

British Columbia reports having spent approximately \$50 million on palliative care programs in 1994/95 within a system which is decentralizing by establishing regional/community structures. The Ministry of

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31 “The cost of the health care system ought never, ever, ever to be used as a justification for ending life prematurely” (Rowand, 9:38). “I do not believe that cost has to be the critical factor in palliative care” (Seguin, 7:41). “As a compassionate and caring nation, we cannot afford not to (afford the cost of the extensive palliative care institutions)” (Mcpherson, 8:20). “It has been said that the true measure of a caring society is seen in the way it treats its most frail members” (McGregor, 4:53). “From the sixties and seventies, perhaps even since the war, came the belief in amelioration, the belief that things could constantly improve. The question we need to ask ourselves as a society is where we want to put our money, because many of the high-tech procedures are not paying off in the benefit that had been promised” (Latimer, 4:22)

32 “Ontario Palliative Care Statement: A Template for the Rest of Canada” *Canadian Medical Association Journal*, 1993,

33 20 hours at McGill; Dalhousie 16+ ; McMaster 15.5; Calgary 11; UBC, Queens and Western from 1 to 3 hours.

34 Neil Macdonald, “Teaching Palliative Care: A Structural Overview,” in Roderick MacLeod, *Teaching Palliative Care: Issues and Implications*, 1993 13.

Health funds palliative care through various programs which link existing hospital and community based services such as home care nursing and the province's one dedicated hospice. Emphasis is placed on symptom management and services appropriate to the evolution of the illness. The province is "looking actively" at providing patients in their homes with drugs and equipment free of charge.<sup>35</sup>

Dr. Williard P. Johnston, Secretary-Treasurer of the Canadian Physicians for Life and family practitioner in Vancouver, says palliative care in B.C. is only just beginning:

In Vancouver, one would expect to have the most highly developed palliative care network in the province, both because of its size and because of the eminence in research and in tertiary patient care. As a primary care physician, I have difficulty finding adequate palliative care facilities for my needy patients. I can assure you that we are in the early stages of developing the entire ethic of palliative care as a medical tradition in this city."

*Johnston, 14:31*

The President of the British Columbia Hospice/Palliative Care Association, told the Committee:

Our organization consists of approximately 100 organized hospices within the province of British Columbia. There is an unknown number of hospices and steering groups that are forming at this time. We are constantly receiving requests for our start-up manual and inquiries about how to go about providing hospice/palliative care in the communities. There are also many volunteers who are providing hospice/palliative care in no organized fashion within our smaller communities. Hospice began in our province with the people [...] hospice/palliative care is only 10 years old in the most advanced areas in British Columbia; [however,] there are many places and people who do not know what hospice/palliative care is.

*Coupal 16:36-37*

Mr. Horgan, Chaplain of St. Paul's hospital in Vancouver where there is an active palliative care unit said:

where there are no hospices located in-hospital, there are hospice interest groups and volunteers working in the community with physicians, with nursing staff, etc. I would say that the work of hospice education and of movement towards facilities in all areas of the province is very definitely underway.

*Horgan, 14:157*

## **Training in Palliative Care**

The Vancouver Hospice program provides training in hospice care through Vancouver Community College in two courses (Palliative Concepts for Professionals in Care Facilities and Caring for Persons With a Terminal Illness). A third course, Advanced Hospice Training, will be offered in 1995. The Vancouver Hospice staff also provide Hospice Orientation to all continuing care staff.

The University of Victoria provides a course in palliative care in the School of Nursing; the British Columbia Medical Association has approved palliative medical care as part of the curriculum at the University of British Columbia, School of Medicine. Training material has also been developed by the Victoria Hospice Society and the British Columbia Hospice/Palliative Care Program.

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35 The "home care" has a palliative care component when drugs and equipment are provided and palliative care services by physicians can be billed to the province.



## Limitations and Gaps in Palliative Care Service Delivery

Palliative care services in British Columbia are dependent on volunteers and their budgets are very limited.<sup>36</sup> Medication and supplies are not yet reimbursed by the province for patients wishing to end their days in their home. Some regions are underdeveloped while others offer extensive services. Finally, “the fragmentation of existing services makes it very difficult to plan and to possibly reorganize services to meet the needs of clients, families and health care providers.”<sup>37</sup>

### ALBERTA

According to the Government of Alberta:

Historically, palliative care has been funded through hospital global budgets, home care programs and long-term care facilities. Palliative care services and programs are developed at the discretion of the organization or agency to meet identified local needs. Some urban hospitals and long-term care facilities have designated funding within their global budgets to support palliative care units or palliative care teams, if demand has warranted a special program.<sup>38</sup>

In 1991/92, the Health Unit/Health Facility Partnership was implemented “to strengthen and enhance the delivery of community-based services to support earlier discharge, to prevent admission to health facilities, and to enhance community-based palliative care services.”<sup>39</sup> In December, 1993, Alberta Health published *Palliative Care: A Policy Framework* in which it identified principles by which a continuum of care and support services would be available to terminally ill patients and their families. These principles include individual and family focus; independence and choice; access to palliative care based on an assessment of needs; palliative care to be offered in any setting; integration of care; support of family and community roles; preference given to care in the home; hospital care as required; development of a multidisciplinary body of knowledge; continuity of care; and coordination of services.

Alberta is cost cutting deeply in health care. The province states that since 1991 Alberta Health has been identifying service improvement and cost cutting targets for each sector of the health system. In April, 1995, Regional Health Authorities became responsible for the development of all health care services in their jurisdiction.<sup>40</sup>

Alberta Health states that the government will support palliative care through reallocating dollars from hospitals to the community. The new Regional Health Authorities will allocate these resources in their respective regions. The Palliative Care Policy Framework (1993) and local/regional needs will guide the Regional Health Authorities in the development and funding of palliative care services.<sup>41</sup>

The impact of the reform on palliative care services is yet to be evaluated. Mr. Hiebert, who represented the Catholic Health Association of Canada before the Committee, declared that:

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36 “The budget of each hospice varies. For the most part, there is no provincial funding. Most of the monies are raised within the community.” (Coupal, 16:49)

37 Fax, Carr, Vancouver Hospice Program, December 5, 1994.

38 Letter, Donald J. Philippon, Deputy Minister, Alberta Health, October 20, 1994.

39 Health Canada, 1993, 16.

40 Alberta Health, 1993, 4.

41 Letter, Donald J. Philippon, Deputy Minister, Alberta Health, October 20, 1994.

Governments in the past have been hesitant to fund palliative care [...] Clearly, the government in our province has changed its view towards supporting palliative care because it is concerned about the [...] health care system.

*Hiebert 14:143*

Dr. L. R. Ohlhauser, Registrar of the Alberta College of Physicians and Surgeons, has written to the Committee that "there is now more emphasis on palliative care in both medical education and in practice." Although there is increased emphasis, not all medical practitioners are satisfied. Traditional medical emphasis on cure and doctor directed over client/family focused care is still prevalent in attitudes and even in some of the education according to some witnesses. The Alberta Palliative Care Association is concerned that the local administrators are not sufficiently aware of palliative care needs. The Association is providing them with information.

### Current Palliative Care Availability

Palliative care is available in most parts of the province but not across all health care sectors, according to Alberta Health and the Alberta Palliative Care Association. However, palliative care is not always accessible by all individuals in the province and in many areas limited expertise or knowledge of the philosophy of palliative care results in poorly delivered care. Free-standing hospices, as well as volunteer services, and psychosocial supports, are not funded directly by Alberta Health at this time. Free-standing hospices are not funded directly by the province.

### Training in Palliative Care

In Alberta, expertise in palliative care is available in major cities from major hospitals in Edmonton, the Hospice Calgary Society, the Alberta Cancer Board, palliative care organizations, and various long-term care facilities. The University of Alberta in Edmonton and the University of Calgary provide some palliative care training as part of nursing and medical curricula. There are also two certificate programs for nurses which are related to palliative care. These courses do not completely address the needs of all palliative care clients but focus mostly on clients with malignancies, pain control needs and AIDS. Distance and cost mean that courses are not easily available to nurses outside of the major urban areas.

### Limitations and Gaps in Palliative Care Service Delivery

The Palliative Care Association of Alberta identified numerous barriers to the development of palliative care services.<sup>42</sup> These limitations summarize the situation in most provinces, according to palliative care advocates:

**Financial:** funding fitted into categories of long-term and acute care do not address the needs of palliative care patients; lack of a standardized statistical reporting system for reporting palliative care services; high cost of medication and equipment if patients return to their homes; insufficient pharmaceutical budgets in facilities; non-coverage, by the province Drug Benefit List of all palliative care-related medications; insufficient community funding for palliative care services.

**Accessibility:** time-lag after request for acute care beds and/or technologies, and difficult access to facilities for patients staying at home; private and appropriate environments are rarely available in facilities; inappropriate compensation for physicians involved in palliative care,<sup>43</sup>

42 Letter, Sandy Doze, Co-Chair Palliative Care Association of Alberta; Maureen Scott, Co-Chair, March 4, 1994

43 Physicians are paid on a fee-for-service basis. Home visits and extra time for a patient are not considered.

palliative care services are not available everywhere in the province; lack of understanding of palliative care patients' special needs by health administrators.

**Education:** lack, in palliative care education, of palliative care professionals and volunteers; lack of a specialized palliative care body of knowledge; lack of communication skills of health care providers; and lack of public knowledge of palliative care services.

**Legislative:** the current *Hospital Act/Nursing Home Act* places limitations on care levels allowed to specific facilities; lack of advance directives or legislation to ensure consideration of patients' choice.

**Coordination:** lack of a continuum of services and lack of adequate linking between services including links to specialty palliative care knowledge.

**Research/Quality:** lack of an evaluation model and standards for palliative care services; lack of research in various palliative care areas, including a focus on outcomes and quality of life for dying individuals.

**Ethics:** medical model of cure vs. care; service priorities; relation with euthanasia/assisted suicide.

## SASKATCHEWAN

According to Dr. Zach Thomas, President of the Saskatchewan Palliative Care Association:

Saskatchewan Health has assigned a high priority for palliative care in the province. Palliative care has been designed as one of the ten core services for which Health Districts are responsible [...] there are palliative care programs at various stages of development throughout the province [...] palliative care is considered an important component of the health care structure of this province and a leading example of integration of different sectors of care and community relevant delivery of care.<sup>44</sup>

In 1994, Saskatchewan Health released, in collaboration with the Saskatchewan Palliative Care Association, its Guidelines for Developing an Integrated Palliative Care Service that would extend existing programs and govern the establishment of new ones. It builds on current programs such as a Home Care Program established in 1978 which provides assessment, nursing, volunteer services and care coordination in 45 districts. Another long-term program, Special Care Home services "is provided by 171 special care homes and 99 hospitals. Approximately 93% of long-term care beds are in special care homes. Most facilities are operated by non-profit boards. 85% of long-term care residents have heavy care needs."<sup>45</sup>

Funding for palliative care services is provided through the Health District which oversees:

that sufficient and appropriate funding is available for acute in-patient care, long-term care and home care [...] extra funds are being directed towards Community palliative care so that not only sufficient home care human resources (nursing, home support) are available but also medications and supplies free of charge to ease the financial burden on patients and families while choosing to remain at home.<sup>46</sup>

The Saskatchewan Palliative Care Association promotes the advancement of palliative care services in the province through partnership with Saskatchewan Health to develop the provincial palliative care policy. It

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44 Letter, Dr. Zach Thomas, President, Saskatchewan Palliative Care Association, December 29, 1994.

45 Health Canada, 1993, 26.



held a workshop in 1994 to facilitate the implementation of this policy throughout the province. It advocates enhancement and development of palliative care programs in Health Districts.

### **Current Palliative Care Availability**

The Saskatchewan Palliative Care Association stated the provincial health care system is a world leader [in] realizing the significance of palliative care as a prime example of the “Wellness Model” of care.” Funds are provided to support a “broad spectrum of palliative care initiatives,” including “full benefit palliative care coverage and introduction of free supplies for palliative care persons in the community.” The actual services provided are:

One full time salaried physician for providing palliative care medical support in one major city. In the other major city there are three physicians who provide part time coverage and receive a component of salary for their time commitments towards palliative care. To a large extent, the day to day medical care is provided by patient’s own family physicians supported by specialists and oncologists. Provision of nursing and other support services are through salaried personnel employed by Health Districts. Individuals and community organizations provide volunteer services, as well as funds, to support areas of activities not funded by the health care districts; such as bereavement support.<sup>47</sup>

While initial palliative care programs were directed towards cancer patients, they are increasingly available to patients suffering from all types of diseases, including HIV/AIDS. The Association also promotes the establishment of a Provincial Palliative Care registry which would be a first of its kind anywhere, and would greatly enhance planning for service delivery and research initiatives.

### **Training in Palliative Care**

The Saskatchewan Palliative Care Association contributes to numerous educational initiatives at all levels in the provinces such as an educational training program of community caregivers in rural areas; it also provides information and resources (phone calls, literature, books, videos, the Association newsletter, etc.. Training for physicians and nurses exists in Regina and Saskatoon. District medical societies and departments of Continuing Education (medical and nursing) organize and provide educational opportunities for physicians, nurses and other care-givers.

### **Limitations and Gaps in Palliative Care Service Delivery**

The Association identifies “management of pain, resolution of psychosocial problems and meeting of spiritual needs” as high priority needs to be met, as well as improving the awareness of both the caregivers and the public in general concerning palliative care programs, adequate provision of beds for long term care of palliative care patients in their own communities, continuous education, development of a body of knowledge in palliative care, and full integration in the health care delivery system leading to the creation of a “smooth flow system without seams and gaps so that persons can receive optimum care at the most appropriate location.”

Dr. Thomas, president of the Saskatchewan Palliative Care Association is optimistic. He stated that the “health care reform initiatives have greatly benefited the development of palliative care services” in Saskatchewan, “as the health care services in each Health District come under one unified administration structure, this has facilitated: need based planning, team approach, appropriate resource allocation, and

46 Letter, Dr. Zach Thomas, President, Saskatchewan Palliative Care Association, December 29, 1994.

47 *Ibid.*



coordinated delivery. This has brought “wholesomeness” to the care being provided and thereby preventing fragmentation and sectorial considerations.<sup>48</sup>

### MANITOBA

There are two palliative care centres in Manitoba; one is at the Riverview Hospital and the other at St. Boniface Hospital. The latter has about 200 active cases on their palliative home care program, which offers a telephone help-line. The Riverview Hospital also offers a home care program. According to Dr. Deborah Dudgeon, Medical Director of the Palliative Care Program at St. Boniface Hospital, most pain problems are managed by general practitioners. She added:

there are a number of rural programs throughout Manitoba as well [...] and there is certainly more palliative care in the community than in institutions, and that is where it should be.

*Dudgeon, 17:53*

Manitoba Health provides palliative care-related services such as home care (therapy, oxygen, dialysis, etc.) and respite care (respite to caring family through short-term admission to a personal care home).

James C. Mcrae, Manitoba Minister of Health, wrote to the Committee that:

palliative care services are categorized as hospital palliative care, community-based home care and other community-based services. Funding for palliative care services is through the funding allocated for hospitals and for the provincial home care program. Hospitals with palliative care programs fund them within the overall budget. The provincial home care program provides a range of services based on assessed individual care requirements. Manitoba Health funds home care services directly or through purchase of service arrangements or through grants to external agencies.<sup>49</sup>

### Training in Palliative Care

Dr. Peter Kirk, Vice President of the Manitoba Hospice Foundation, and Department Head of Family Medicine at the University of Manitoba told the Committee:

that for all family practice residents (the postgraduate program) should receive as part of their core training, training in palliative care. The program is two-year; one month is spent by all residents in palliative care. At the undergraduate level, an average of nine hours is devoted to palliative care. The Manitoba Hospice Foundation has a program for volunteers which involves 16 hours.

*Kirk, 17:53.*

### Limitations and Gaps in Palliative Care Service Delivery

Dr. Dudgeon considers that palliative care is given a low priority in the overall health care structure of Manitoba. For her, the province has not given any official or unofficial encouragement to the advancement of palliative care. The two major clients' needs which are not met are: home care support, and absence of knowledgeable physicians and nurses in the community for assessment and treatment of patients. One of the

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48 *Ibid.*

49 Letter, James C. Mcrae, Manitoba Minister of Health, October 4, 1994.

major barriers to the development of palliative care is the insufficient funding for human resources and education.<sup>50</sup>

## ONTARIO

The Ontario Government is making significant changes to its health care system. In December 1992, the Ministry of Health announced an annual \$4.8 million redirection of funds for:

Exciting new initiatives in community palliative care, the care of the dying patients and their families. These initiatives were aimed at improving the care available to such patients in their home and in long-term care institutions by means of four initiatives: education of interdisciplinary service providers, education of family physicians, support and maintenance of hospice volunteer visiting programs, and the establishment of pain and symptom resources teams in all areas of Ontario.<sup>51</sup>

The Ontario Palliative Care Association stresses that: "the most outstanding feature of the whole process of these initiatives was the key concept of partnership with many diverse groups sharing a common interest in improving palliative care delivery in Ontario."<sup>52</sup>

Recently, the Ministry of Health has been focusing on the community-based service sector. With Bill 173, multi-services agencies will be created to manage and coordinate service delivery. "With the implementation of this Act, enhanced services for palliative care patients will be available in the community. This will allow for more flexibility in planning for services needed for palliative care patients at home."<sup>53</sup>

### Current Palliative Care Availability

According to the Ontario Palliative Care Association:

Palliative care is provided in a number of settings. Services range from full palliative care teams and designated units in hospitals, to beds scattered throughout facilities with a variety of personnel trained in the provision of palliative care. The 38 home care programs in Ontario provide palliative care services to patients in their own home. Some programs have designated palliative care case managers with specialized interdisciplinary palliative care teams. The services are often enhanced by volunteers through local hospice programs. Specialized hospital palliative care teams work in partnership with community service providers acting as expert resources in pain and symptom management and providing crisis intervention when needed.<sup>54</sup>

On June 15, 1994, Ms. Heather M. Balfour, of the Community Hospice Association of Ontario, described to the Committee the organization of hospice programs affiliated to her organization in Ontario:

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50 Fax, Dudgeon, St-Boniface General Hospital, November 30, 1994.

51 Fax, Ontario Palliative Care Association, February 6, 1995.

52 *Ibid.*

53 *Ibid.*

54 *Ibid.*

Hospice programs are primarily volunteer support oriented, although some of them have nursing, therapy, social work and/or physicians on staff or on a service arrangement. Most of our hospices provide care to people in their own homes, although we do have one that is a free standing hospice. Many of our hospice programs provide a combination of services, including day-care and day-care centres, care to client in a hospital or in a nursing home, and also respite care. Most of our hospice programs are not diagnosis specific. Most of our hospices do get some provincial government funding as a result of the recent Ontario Ministry of Health Palliative Care Initiative. The bulk of their financial support comes from generous individuals, foundations and community groups.

*Balfour 10:5.*

The first Ontario hospice was created in 1979 in Windsor. In 1989, there were eight hospices in the province. (Most of the 60 affiliated hospices were created in the 1990s) Ms. Balfour expects that more hospice programs will be developed.

### **Training in Palliative Care**

In December, 1992, the Ministry of Health provided funds for 30-hour courses for service providers and family physicians. It is also planned that 124 family physicians will receive formal education in palliative care as well as practicum in a palliative care setting. The five medical schools in the province share the responsibility for this program. Training is also available for volunteers.

### **Limitations and Gaps in Palliative Care Service Delivery**

Although progress is being made, the development of palliative care in Ontario must overcome a traditional absence of government policy, lack of financial support, professional and public ignorance and apathy. According to Ms. Balfour hospices lack staff 95% of persons working there are volunteers. The Association's view is that:

The issues that confront dying patients and their families and community care providers are varied and complex. The funding provided through these [government] initiatives represents a limited response to the palliative care needs of a large, culturally and socially diverse population. Further support will be needed to meet the immediate and future needs for palliative care expertise in Ontario.<sup>55</sup>

## **QUEBEC**

### **Current Palliative Care Availability**

Quebec has a unique system where some doctors receive fixed salaries. This is an improvement over the fee-for-scheduled service system of other provinces wherein billable time for palliative work is a major problem. The building of multidisciplinary palliative care teams is thus facilitated. According to Dr. Mount:

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55 Fax, Ontario Palliative Care Association, February 6, 1995.

Quebec handles the funding mechanism differently. The problem in most provinces, including Ontario, is that you cannot make a living doing palliative care because of the nature of the medical acts on a medical act basis. There just are not enough acts of the kind that are remunerated. Quebec instituted a *salaire fixe* or vocation [...] It is a way of putting physicians on salary to do palliative care. None of us get rich doing it, but we make a good living.

Mount 5:39

The originality of the Quebec model is: "the willingness to integrate health and social services in a common process of opening care practices to the more social dimensions of illness, misery and suffering."<sup>56</sup>

Dr. Louis Dionne, Executive Director of the Maison Michel Sarrazin, provided the Committee with a positive portrait of palliative care services in Quebec:

Most university hospitals have created palliative care services for terminally ill patients including home care, a consultation team, a clinic for symptom control and a bereavement service. Some are oriented towards research and teaching. La Maison Michel Sarrazin is a teaching center that has been affiliated with Laval University for 10 years [...] It has raised a movement called *Le mouvement des soins palliatifs* throughout the province of Quebec. In Montreal there are good centres such as l'Hôpital Notre-Dame and l'Hôpital Royal Victoria that have done exactly the same. This movement has created a desire for the people who look after patients to have palliative care in their own institutions.

Dionne, 13:22

La Maison Michel Sarrazin operates a home-care program in collaboration with local health centres and the Centre locaux de services communautaire. L'Association québécoise des soins palliatifs stated in its brief: palliative care services are implemented in all regions in Quebec, however, they are not well enough known and are badly operated."<sup>57</sup>

The palliative care service of the Royal Victoria in Montreal was created in 1974. It was the first service to integrate a home maintenance program, a consultative service for all hospital's patients, an external clinic, a bereavement program for families, and a specialized hospital unit which included teaching and research activities. It is the first in the world to be integrated into a short-term hospital. In St-Boniface's Hospital, in Manitoba Dr. Paul Henteleff, the president of the Canadian Palliative Care Association was the first, in Canada, to open a palliative care unit. The Royal Victoria palliative care service is still, after 20 years, an international reference model. Finally, in Montreal, l'Entraide Ville-Marie was the first home care service to be organized in Canada.

## Training in Palliative Care

In 1991, the McGill Medicine Faculty and its Oncology Department, created the Palliative Care, Medicine, McGill division to maintain and facilitate the development of clinical programs and to ensure minimal palliative care standards in all participating hospitals. They also have the responsibility to devise a pre-doctoral curriculum, a post-doctoral teaching program and continuous medical training, including the organization, every second year, of the Care for Terminally Ill patients International Congress. There also is a clinical and psycho-social research program with affiliated institutions.

56 Rapport de la Commission d'enquête sur les services de santé et les services sociaux, (Commission Rochon) 1988, 400-401.

57 L'Association québécoise des soins palliatifs, November 17, 1994.



The Maison Michel Sarrazin created with l'Université Laval "La chaire de soins palliatifs de l'Université Laval" in 1992 to foster the development of teaching and research in palliative care. Activities are included in the curriculum of the 1st year as well as the 4th year for medical students.

### Limitations and Gaps in Palliative Care Service Delivery

The Quebec government strongly supports palliative care services and is geared toward providing a proactive response to the population's needs, according to Dr. Dionne. He further stated that education in palliative care is provided within the Quebec city region to almost all generalists and specialists. There is room to extend education and training opportunities to all health care professionals.

Dr. Dionne pointed to further research on the control of pain and especially suffering related to the psycho-social situation of the patient. He also believes that the public should be provided with current information on palliative care and other related issues.

## NEW BRUNSWICK

### Current Palliative Care Availability

Dr. Sydney Grant, Medical Director for the New Brunswick Extra-Mural Hospital and Medical Director of the Palliative Care Unit at the Dr. Everett Chalmers Hospital in Fredericton told the Committee "there is unofficial encouragement in our province in the sense that we have palliative care units in our major hospitals and that palliative care directors (when providing palliative care to patients) are paid on a fee-for-session basis"<sup>58</sup>. He also states that "there is enough funding in this province for palliative care"<sup>59</sup>. The following exchange with Reverend Kenneth Weir of New Brunswick is also worth noting:

Rev. Weir: We have something which is unique in Canada. We have the extra-mural hospitals and nurses who are extra-mural [...] We have this available in our province and we have nurses and ancillary staff there. We also have trained professionals in our institutions. People die at home and in institutions all the time with support systems

Q. [in New Brunswick palliative care is available to nearly 100 per cent of the population?]

Rev. Weir: Absolutely.

Q. [with adequate pastoral, nursing and medical care?]

Rev. Weir: Yes.

Q. [With a good team?]

Rev. Weir: Yes.

*Weir, 24:28-29*

The New Brunswick Extra-Mural Hospital is responsible for palliative and acute care programs, as well as for a long-term home health program in New Brunswick. It was established in 1981 to address interrelated major health problems such as growth and aging of the population, high costs of construction and operations for hospital/care institutions, and a high prevalence of long-term degenerative conditions.

The New Brunswick Extra-Mural Hospital is a hospital corporation under the *New Brunswick Hospital Act*, patients are admitted, cared for and discharged by physicians, the staff is all health care professionals, and all patients have the status of hospitalized patients for insured services provided under the provincial legislation. Its objectives are to provide:

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58 Fax, Haslam, December 8, 1994.

59 *Ibid.*

- 1) an alternative to hospital admission
- 2) an alternative or postponement of admission to nursing homes
- 3) long-term continuous home health care to chronic invalids, disabled of all ages, and terminally ill persons

Major services such as nursing (on a 24-hours basis), dietary, respiratory and occupational therapies, physiotherapy and social work (home makers, meals-on-wheels and sick room supplies), x-ray and laboratory services are offered through other institutions.<sup>60</sup> The target population is the provincial population of New Brunswick., i.e. “those persons whose illnesses do not, or no longer, require the 24-hour surveillance, high technology, and the concentration of diagnostic and treatment services characteristic of the modern active treatment hospital”.

### **Limitations and Gaps in Palliative Care Service Delivery**

Dr. Grant points to “some resistance on the part of physicians to become involved” in palliative care because of a lack of awareness of palliative care services and philosophy. For him, the main priority is public education on palliative care and death and dying issues. He also refers to a substantial need for respite care.

Ms. Brenda Haslam, Chair of the New Brunswick Palliative Care Association and Board Member of the Canadian Palliative Care Association agrees that the chief need is education for health care professionals and the general public. Stronger support services, including respite care are required.

## **NOVA SCOTIA**

In 1991, the province had the highest cancer mortality rate in Canada for women and the second highest for men, according to Statistics Canada. In 1993, there were 2,300 cancer deaths and 4,700 new cancer cases. The first palliative care programs in the province were developed to meet the needs of dying cancer patients.

Nova Scotia was one of the first provinces, in the mid-eighties, to adopt guidelines for palliative care services<sup>61</sup>. The Government of Nova Scotia has adopted in principle a modification to its physicians’ compensation system. The new arrangement is based on a session-fee scheme and is applicable to doctors practising in palliative care. The provincial Metropolitan Hospital recommended the establishment of a coordinated program of palliative care services into a provincial program of comprehensive oncology services available everywhere.

### **Current Palliative Care Availability**

Palliative care services are “initiated and supported by community efforts in all sectors”<sup>62</sup>. There is also a palliative care service (6 beds, a consultation service and a home care service) funded by the province in the Camp Hill Medical Centre in Halifax.

### **Training in Palliative Care**

“There are 16 hours in the undergraduate medical curriculum specifically assigned to palliative care at Dalhousie University School of Medicine, while the Camp Hill Medical Centre, in Halifax, is affiliated with Dalhousie University as a teaching institution. Medical students may choose to do elective or selective

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60 New Brunswick Extra-Mural Hospital, *Summary of Operations*, 6.

61 Nova Scotia Palliative Care Association 1994, (A) 3.

62 *Ibid.* 1994 (B) 5.

rotations within the Palliative Care Service, and family medical residents may choose to do an elective in palliative care; in 1995, training periods will also be available for nurses.<sup>63</sup>

### **Limitations and Gaps in Palliative Care Service Delivery**

Most palliative care services are situated in the Halifax Metro area and are accessible to a minority of patients according to the Nova Scotia Hospice/Palliative Care Association. Funding throughout Nova Scotia is considered “fragmentary and inconsistent” by Dr. Ina Cummings. She identifies education and resources as the major barriers to the development of palliative care in the province.

## **PRINCE EDWARD ISLAND**

### **Current Palliative Care Availability**

Ten beds are available in the province for palliative care. The Prince Edward Home, a long-term care facility, provides eight of them. A part-time medical specialist and two on-call physicians with palliative care training provide services. The average length of stay is 30 days and there often is a waiting list. The Prince Edward Home does not provide a 24 hour home care service. It can rely on approximately 200 volunteers. The Western Hospital provides 2 other beds in its palliative care unit. Referrals are made by family, health professionals and home care workers.<sup>64</sup>

### **Limitations and Gaps in Palliative Care Service Delivery**

In July, 1994, The Island Hospice Association identified limitations and gaps in the delivery of palliative care services in Prince Edward Island. They identified the problems as follows:

No official government policy on palliative care services.

No central information or referral to services and a “fragmented system of limited, unequal and unpredictable access to palliative care services [...] a convoluted entry point to available services”.

Limited home care support, and no outpatient, consultation or formal educational services. Most resources are in the Charlottetown area.

A lack of professional and public education concerning availability of palliative care services. Patients of modest means are forced to rely exclusively on family physicians, who may have neither the time nor the expertise required to manage complex physical problems or to coordinate all the support required for the patients and their family.

A lack of formalized physicians’ consultation service, which leads to large differences in pain and symptom management.

Limited after-hours support available: current home care programs are built on a model of short-term convalescent and long-term maintenance care for the elderly and the disabled.

A lack of alternative choices to institutional care.<sup>65</sup>

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63 Letter, Ina Cummings, November 3, 1994.

64 Island Hospice Association, 1994, 19.

65 *Ibid.* 5-6.

## NEWFOUNDLAND

### Current Palliative Care Availability

There is an eight bed facility at St. Clare's Mercy Hospital in St. John's and Dr. Margaret Scott's position as Provincial Palliative Care Consultant is funded by the Memorial University of Newfoundland and the Newfoundland Cancer Foundation. Dr. Scott says that local clinics and hospitals are developing palliative care services: "St.-Clare's has extended its service to acute care consultations; and the Cancer Foundation is establishing a designated interdisciplinary team. Funding for St.-Clare's palliative care service was \$650,000 in 1993 (all other programs were part of the provincial Department of Health global budget). However, Dr. Scott did not have the average cost for palliative care beds in a hospital, hospice, or home care."<sup>66</sup>

The Newfoundland and Labrador government includes palliative care within its program of Continuing care but makes no special allocations for it. In a letter the provincial Minister of Health said the province "does not fund programs - funding is from institutional global budgets. A facility can set its own budget for specific programs within their global allocation."<sup>67</sup>

### Training in Palliative Care

The Newfoundland and Labrador Minister of Health, Lloyd G. Matthews, said in his letter:

Continuing education of physicians is done through the Division of Continuing Education, Faculty of Medicine, Memorial University of Newfoundland, and education of institutional staff by in-service and continuing educational programs within the specific facilities. There are opportunities for staff to attend conferences and education opportunities both outside the facility and outside the province.

### Limitations and Gaps in Palliative Care Service Delivery

Joan Davis, Assistant Deputy Minister of Health, identifies five gaps in service delivery: "availability of physicians who are willing to provide services in an individual home; access to services across geographic areas of the province; availability of equipment such as the pump for continuous subcutaneous infusion of medications (CSCI) for pain management; the home support often needed exceeds the available financial resources; and support and counselling for the family is very limited." Dr. Scott adds that some patients are not referred soon enough and that some health care professionals do not perceive palliative care as a therapeutic option.<sup>68</sup>

Dr. Scott identified three major issues for the near future: "professional attitude, knowledge and availability; public awareness of palliative care; and ethical and research issues at all levels." She recommends emphasis on palliative care in undergraduate and postgraduate education, physicians' continuing education, and public debate.

66 Fax, Margaret Scott., December 2, 1994; accompanying text from Joan Davis, Assistant Deputy Minister (ADM) of Health, and input from E. Davis, Chief Executive Officer, Health Care Corporation of St. John's.

67 Letter, Newfoundland and Labrador Minister of Health, November 14, 1994.

68 Fax, Margaret Scott, December 2, 1994; accompanying text from Joan Davis, Assistant Deputy Minister of Health, and input from E. Davis, Chief Executive Officer, Health Care Corporation of St. John's.



## NORTHWEST TERRITORIES

The Northwest Territories does not provide separate funding for palliative care: "funding for palliative care cannot be isolated from the rest of the health care budget; it would however be very small in comparison to the overall health care budget."<sup>69</sup>

### Training in Palliative Care

The Department of Health and Social Services stated that the Northwest Territories encourages the advancement of palliative care education through "a contract for gerontology services; education is one of the roles of the gerontologist and topics relating to palliative care have been included in the past for health professionals and community members."<sup>70</sup> The Department said individual facilities provide training to their staff.

## YUKON

According to Joy Kajiware, Director Continuing Care, Health and Social Services for the Yukon, "unofficial support is provided through funding for hospice [care] incorporated in global funding for hospital, operating budget for Home Care and continuing care facilities and contribution agreements to hospice."<sup>71</sup>

## CONCLUSION

Information regarding the current status of palliative care in the provinces was provided by provincial health departments' officials and by representatives of palliative care associations who responded to an interview by telephone and filled out a questionnaire describing palliative care in their province, and by witnesses who appeared before the Committee.

Respondents felt the commitment to palliative care was substantial in four provinces: Saskatchewan, Ontario, Quebec and New Brunswick, while respondents felt that a low priority was given to palliative care in Manitoba and Prince Edward Island. Respondents from other provinces either expressed their concerns about the future of these services or stressed considerable gaps in services.

To summarize, the situation of palliative care in Canada reflects the current health care situation. It is characterized by change and great expectations as well as concern for the future since health care services are in a process of decentralization.

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69 Letter, Elaine Berthelet, Acting Deputy Minister, October 11, 1994.

70 *Ibid.*

71 Letter, Kajiware, Continuing Care, Health and Social Services, Yukon, November 2, 1994.

## Appendix N

### Recent Reports from Foreign Jurisdictions

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*In 1994, a Select Committee of the House of Lords was struck to consider the "ethical, legal and clinical implications of a person's right to withhold consent to life-prolonging treatment and the position of persons who are no longer able to give or withhold consent; and to consider whether and in what circumstances actions that have as their intention or likely consequence the shortening of another person's life may be justified on the grounds that they accord with that person's wishes or with that person's best interests...". In addition, in the United States, several states had appointed task forces to analyze and make recommendations to the state legislatures with respect to end of life issues. The complete list of recommendations of the Medical Ethics Committee of the House of Lords and the New York State Task Force on Life and the Law have been reproduced below.*

#### **House of Lords Select Committee on Medical Ethics: Recommendations - January 1994**

We recommend that there should be no change in the law to permit euthanasia.

We strongly endorse the right of the competent patient to refuse consent to any medical treatment.

If an individual refusal of treatment by a competent patient is overruled by the Court, full reasons should be given.

We strongly commend the development and growth of palliative care services in hospices, in hospitals and in the community.

Double effect is not in our view a reason for withholding treatment that would give relief, as long as the doctor acts in accordance with responsible medical practice with the objective of relieving pain or distress, and without the intention to kill.

Treatment-limiting decisions should be made jointly by all involved in the care of a patient, on the basis that treatment may be judged inappropriate if it will add nothing to the patient's well-being as a person.

We recommend that a definition of pvs and a code of practice relating to its management should be developed.

Development and acceptance of the idea that, in certain circumstances, some treatments may be inappropriate and need not be given, should make it unnecessary in the future to consider the withdrawal of nutrition and hydration, except where its administration is in itself evidently burdensome to the patient.

Treatment-limiting decisions should not be determined by considerations of resource availability.

Rejection of euthanasia as an option for the individual entails a compelling social responsibility to care adequately for those who are elderly, dying or disabled.

Palliative care should be made more widely available.

Research into pain relief and symptom control should be adequately supported.

Training of health-care professionals should prepare them for ethical responsibilities.

Long-term care of dependent people should have special regard to maintenance of individual dignity.

We support proposals for a new judicial forum with power to make decisions about medical treatment for incompetent patients.

We do not recommend the creation of a new offence of "mercy killing".

We strongly endorse the recommendation of a previous Select Committee that the mandatory life sentence for murder should be abolished.

We recommend no change in the law on assisted suicide.

We commend the development of advance directives, but conclude that legislation for advance directives generally is unnecessary.

We recommend that a code of practice on advance directives should be developed.

We do not favour the more widespread development of a system of proxy decision-making.

HL Paper 21-I, January 1994, page 58



### **When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context The New York State Task Force on Life and the Law. May 1994**

The principles identified by the Task Force are set forth below. The Task Force believes that these principles will offer important guidance for physicians while respecting the need for professional judgment in formulating treatment recommendations.

- Physicians have a professional obligation to provide appropriate pain relief and palliative care.
- Physicians have a professional obligation to assess and treat depression or refer patients for treatment.
- Physicians should not refrain from discussing a patient's suicidal thoughts, and indeed should explore, discuss, and respond to a patient's indications of suicidal thinking. This is an important aspect of care and also may facilitate prevention of suicide.
- Physicians should not perform euthanasia or assist a patient to commit suicide. However, the provision of medication that may hasten a patient's death is ethically and professionally acceptable, provided the medication is not intended to cause the patient's death or to assist the patient to commit suicide, and the medication is provided in accord with accepted medical standards.

- A physician may appropriately provide medication in the face of a known risk of suicide, provided that the benefits of the medication outweigh the risk and the physician has considered the comparable benefits and risks of alternative treatment options.
  - The provision of medication used by a patient to commit suicide does not, in itself, establish that the physician intended to assist the patient to commit suicide. Rather, an evaluation of the physician's intent must take into account a range of factors, such as the physician's reasons for providing the specific amount and type of medication, and whether the amount and type of medication could have served a legitimate medical purpose for the particular patient in light of identified treatment goals.
1. Patients' participation in treatment decisions contributes to their sense of self and well-being. Physicians should seek patients' participation in decisions about withdrawing or withholding life-sustaining treatment early enough in the course of illness to give patients a meaningful opportunity to have their wishes and values respected. (p. 153)
  2. Health care professionals have a duty to offer effective pain relief and symptom palliation to patients when necessary, in accord with sound medical judgment and the most advanced approaches available. (p. 158)
  3. Physicians and nurses must be aware that psychological dependence on pain medication rarely occurs in terminally ill patients. While physical dependence is somewhat more common, proper adjustment of medication can minimize any negative effects. Concerns about psychological or physical dependence should not prevent patients from receiving appropriate palliative treatments. (p. 160)
  4. The provision of appropriate pain relief rarely poses a serious risk of respiratory depression. Moreover, the provision of pain medication is ethically and professionally acceptable even when such treatment may hasten the patient's death, if the medication is intended to alleviate pain and severe discomfort, not to cause death. (p. 162)
  5. The education of health care professionals about pain relief and palliative care must be improved. Training in pain relief and palliative care should be included in the curriculum of nursing schools, medical schools, residencies, and continuing education for health care professionals. In addition, biomedical research facilities should engage in further research in the physiology of pain and its appropriate relief, both at the basic and the clinical levels. (p. 165)
  6. Hospitals and other health care institutions should explore ways to promote effective pain relief and palliative care and to remove existing barriers to this care. (p. 167)
  7. Public education is essential to improve pain relief practices. Nurses and physicians should create an atmosphere that will encourage patients to seek relief of pain. To the extent possible, strategies for pain relief should give patients a maximal sense of involvement and control. (p. 169)
  8. Insurance companies and others responsible for health care financing should promote effective pain and symptom management and address barriers that exist for some patients. (p. 170)
  9. New York State statutes regulations should be modified to improve the availability of medically necessary analgesic medications, including opioids. This should be done in a balanced manner that acknowledges the importance of avoiding drug diversion. (p. 171)



10. Health care professionals should be familiar with the characteristics of major depression and other common psychiatric illnesses, as well as the possibility for treatment. They must be sensitive to the special factors complicating the diagnosis of these conditions among the elderly and the terminally ill. Physicians must also be trained to distinguish major clinical depression from the sadness and temporary reactive depression that often accompany terminal illness. Major clinical depression is generally treatable and can be treated effectively even in the absence of improvement in the underlying disease. Patients should also receive appropriate treatment for less severe depression that often accompanies terminal illness. (p. 175)
11. It is common for terminally ill patients to have suicidal ideation, although patients rarely act on such thoughts. Physicians should create an atmosphere within which patients feel comfortable expressing suicidal thoughts. Discussion with a physician or other health care professionals about suicide does not prompt suicide; on the contrary, talking with health care professionals often decreases the risk of suicide. (p. 177)
12. When a patient requests assisted suicide or euthanasia, a health care professional should explore the significance of the request, recognize the patient's suffering, and seek to discover the factors leading to the request. These factors may include insufficient symptom control, clinical depression, inadequate social support, concern about burdening family or others, a sense of hopelessness, spiritual despair, loss of self-esteem, or fear of abandonment. These issues should be addressed in a process that involves both family members and health care professionals. (p. 179)

## Appendix O

### Medical Decisions Concerning the End of Life in the Netherlands

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The Special Committee learned early in its study that the Netherlands' experience with euthanasia and assisted suicide was particularly controversial in Canada. In part, this was probably because of misunderstandings as to the status and definition of euthanasia in the Netherlands. Euthanasia and assisted suicide are criminal offences under the equivalent of our *Criminal Code*, but neither action is prosecuted if certain conditions are met and safeguards observed. Because of differences in the structure of the criminal law, this situation would not be possible in Canada and can be difficult for Canadians to grasp. The legal situation and the definition of euthanasia in the Netherlands are discussed in detail in section 2.0 of this paper.

Partly as a result of legal and definitional differences, some witnesses said that euthanasia was performed far more often there than was officially admitted. Others suggested that the introduction of semi-legalized euthanasia had inhibited the development of good palliative care, in contrast to England where euthanasia is illegal and there is an extensive network of hospices. Still other witnesses argued that the Dutch example supports the "slippery slope" argument: that any condonation of euthanasia or assisted suicide detracts from the absolute value of life and will inevitably lead to its increasing prevalence among both consenting and non-consenting patients. Particular concern was expressed for the elderly or disabled, who might feel social or emotional pressure to request euthanasia so as not to be a burden on their family or society.

In order to deal with these concerns, the Committee held a video-conference on October 25, 1994 with a number of Dutch legal and medical experts experienced in the issues of euthanasia and assisted suicide.<sup>72</sup> The video-conference included two sessions lasting more than six hours. The following paper is based on the results of those discussions, as well as on background documentation published in both the Netherlands and Canada.

In his introductory address to the video-conference, Dr. Gerrit van der Wal addressed criticisms of the Dutch system and described the concerns about euthanasia and assisted suicide that exist in the Netherlands itself:

The argument that the Dutch practice of euthanasia is fuelled by scarcity of health care resources, especially for elderly people in nursing homes, has no support. Most cases of euthanasia take place at home and concern patients who, after hospitalization and treatment have proven ineffective, have a life expectancy of less than a month...

It has also been argued that pain treatment in the Netherlands is insufficient, and, hence, the argument continues that patients are forced into an unnecessary wish for euthanasia. Whether or not this is the case — and I do not believe that it is so — it is not of significant

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72 See Appendix A for a list of participants.

importance for the practice of euthanasia, since in only about 5 per cent of cases is pain the most important reason for requesting euthanasia.

Finally, it has been argued that the Dutch experiment will inevitably lead downhill — the slippery slope argument... It must be maintained that openness and critical investigation are the most important ingredients for the prevention of a slippery slope.

Do we have problems? Yes, of course, we have problems. I hope this presentation has shown that there are at least three main issues with which we are confronted: first, the substantial existence of cases of unrequested termination of life and a related gray area; second, the reporting of cases of euthanasia to the public prosecutor; third, the need for improvement of the quality of the medical community's views and performance regarding the end of life.

*van der Wal 20:10-11*

Although it seems probable that the approach of the Netherlands to euthanasia policy will continue to generate controversy, there is one point on which there appears to be consensus. At no point was it suggested to the Committee that the Netherlands model could be successfully transferred to Canada. There is much to learn from the Netherlands, if only because the Dutch approach has resulted in better data on euthanasia being available than in societies where euthanasia remains illegal. However, Dutch experts are the first to point out that the Netherlands' approach to euthanasia evolved from specific aspects of Dutch culture, and is not transferable. Dr. van Delden, one of the participants in the video-conference, has put it as follows:

Does the Dutch approach to euthanasia provide a model for Canada? Apart from the normative part of any answer, my response would be a caveat: euthanasia is not a subject to be treated out of context. If you take euthanasia policy from the Dutch context and insert it into another health care system and culture, a disaster might result. I do not want to suggest that euthanasia is only acceptable (if at all) in the Netherlands; but only that euthanasia cannot be separated from its cultural context.<sup>73</sup>

## **1. The Socio-Medical Background**

### **1.1 The Cultural Setting**

The Netherlands has a population of 15 million people, and had 129,000 deaths in 1990, the year the van der Maas study was undertaken (see section 3.0 for a description of this study). The Royal Dutch Medical Association has noted that a variety of social factors led to the current view on euthanasia: increasing emphasis on patient decision-making, and an openness on the part of doctors to discuss with their patients their condition, treatment and prognosis; an increasing emphasis on personal autonomy; and the focus of Dutch churches, other than the Roman Catholic Church, on moral choices made by the individual.<sup>74</sup> In 1991, the religious affiliation of the population aged 18 years and over was 34 per cent Roman Catholic, 17 per cent Dutch Reformed Church, 8 per cent Reformed Churches, 5 per cent other religious affiliation, and 37 per cent with no religious affiliation.<sup>75</sup>

Commentators on the Dutch cultural milieu invariably mention an entrenched pattern of openly discussing difficult issues.

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73 "Euthanasia in the Netherlands: The Medical Scene", in Barney Sneiderman and Joseph M. Kaufert, eds., *Euthanasia in the Netherlands: A Model for Canada*, Legal Research Institute of the University of Manitoba, 1994, p. 25.

74 House of Lords, *Report of the Select Committee on Medical Ethics*, London, 31 January 1994 Appendix 3, pp. 64-66.

75 *The Statesman's Year Book*, edited by Brian Hunter, 130th edition, 1993-94, pp. 998-999.

In terms of culture, the former cabinet answered a question from Parliament concerning why the Netherlands seems to be so much more advanced in [euthanasia policy]. The official answer was that it has something to do with Holland's historical background; that the Dutch have always been an open and honest people. It was stated that they are a self-determined people who want what they think is good for themselves.

These attributes combined with the honesty to name an issue and to speak openly have taken us a step forward in the Netherlands. I do not pride myself on this. It is simply the historical set-up.

*Nieuwenkamp 21:31*

Dr. van Delden has put it as follows: "I can safely say that Dutch society is one without extremes. In a sense almost everyone belongs to the middle class, and this probably has some bearing upon the fact that as a society we do not operate in a very antagonistic or legalistic way. Ours is a society characterized by the philosophy of "talking it over again," of trying to reach consensus."<sup>76</sup>

From the Dutch point of view, the difference between their experience and that of other countries is largely the openness with which the Dutch discuss the issue of euthanasia. The information that they receive from other countries indicates that euthanasia, by the Dutch definition, is being practised clandestinely.

It is the openness [in the Netherlands] which is the main difference, not the factual situation with regard to these medical decisions concerning the end of life.

*Legemaate 21:32*

## 1.2 The Health Care System

The Dutch are proud of their health care system, which is highly developed and universally available. In 1991, the following figures applied:

The total cost of health care was 51.4 billion guilders, or 9.6% of the gross national product.<sup>77</sup>

There were 165 hospitals which supplied modern health care with state of the art technology. There are 60,000 beds for a population of 15 million. Most of the health care institutions are private, non-profit institutions.

Every Dutch citizen was registered with one of the 6388 *huisartsen* or family physicians (GP's). Most primary care is provided by the G.P. in the patient's home, or in an office in the physician's home. The family physician lives in the same neighbourhood as his patients, makes house calls when the patient is too ill to come to the office, and normally has the entire family in his care. 75 per cent of the Dutch see their G.P. at least once a year.

There is a mixed system with private insurance and national health insurance under the Health Insurance Act. About 60 per cent of all inhabitants are insured under the latter scheme for virtually all health care expenses.

Only 2 percent are uninsured, but even they are covered by the *Exceptional Medical Expenses (Compensation) Act* which provides for a national insurance scheme under which everyone is insured regardless of income. The *Act* covers serious medical risks (such as a stay in hospital

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76 J.J.M. van Delden, "Euthanasia in the Netherlands: the Medical Scene", in *Euthanasia in the Netherlands: A Model for Canada?*, p. 23.

77 In Canada, health expenditures levelled off at 10.1% of Gross Domestic Product (GDP) in both 1992 and 1993. (Health Canada, National Health Expenditures in Canada, 1975-1993, p. 3).



longer than one year and admittance to a nursing home) which cannot be borne by the patient personally and for which it is difficult to obtain insurance cover.

There is a legal duty imposed on all health care professionals to provide necessary care. Refusing or discharging a patient for economic reasons is a criminal offence.<sup>78</sup>

Even though nearly all Dutch people are insured Dr. Bakker did caution the committee that economic considerations must be kept in mind.

Up until now in the Netherlands, only the medical considerations have been of importance. There are no economic considerations in decisions concerning the end of life because 100 per cent of the people in the Netherlands are insured for their medicare and all other kinds of care. It is only the medical consideration that count at this moment.

However, we must be careful of that. It is an important point to keep in mind, and constant control with no economic considerations comes into the picture in this respect.

*Bakker 21:67*

In the vast majority of cases, the patient-physician relationship is longstanding, perhaps 10 or 20 or 30 years, at the time a request for euthanasia is made.<sup>79</sup>

The Royal Dutch Medical Association has a membership of 25,000, plus an indirect association with 8,000 to 10,000 physicians. The Dutch Physicians' League, an organization of doctors opposed to euthanasia, has a membership of about 650 physicians. There are approximately 40,000 doctors in the Netherlands in total<sup>80</sup> and some belong to both organizations.<sup>81</sup>

Even within the Dutch Physicians League, there are differing viewpoints on the best approach to opposing euthanasia. Dr. Zbigniew Zylicz, for example, is trained in the British school of palliative care, and the founder and medical director of the Hospice Rosenheuvel. His reason for founding the hospice was to prevent euthanasia through good palliative care.

Zylicz makes no secret of his ardent opposition to euthanasia. He is one of the 600 doctors who are members of the Nederlands Arstenverbond (NAV), or Dutch Physicians' League, which split from the Royal Dutch Medical Association over its stand on abortion and euthanasia.

But Zylicz disagrees with the NAV's anti-euthanasia tactics which consist, in part, of mud-slinging against mainstream Dutch physicians and the use of what he calls questionable research data. The NAV's tactics are "too radical, and only reinforce the polarized views on the subject, Zylicz said."<sup>82</sup>

The role of nurses in the health care system, and more particularly in the issue of euthanasia, was not completely clarified by the video-conference. The one nurse who participated indicated that a nurse's role in decision-making could vary considerably depending upon the physician and head nurse involved:

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78 van Delden, "Euthanasia in the Netherlands", pp.23-24.

79 Mishara 2:36

80 Dillman 21:25; House of Lords, Appendix 3, pp. 64-66.

81 Bakker 21:36

82 Mullens, "A place where euthanasia is talked about but is not offered", in *Euthanasia: Dying for leadership*, p. 33.

It is sometimes the case that within the same hospital a nurse on one ward will be asked to participate in decision-making while on another ward a nurse will not be asked to participate in that process.

*Vlaming 21:20*

There also seemed to be some disagreement about whether a nurse's personal views on euthanasia could affect her or his career, not dissimilar to the debate that takes place in Canada about the effect of a nurse's views on abortion on her or his career.

I would like to point out that for nurses who do not object to euthanasia, there is no problem. However, for nurses who do object to euthanasia, there can be career difficulties. Those who object will never be promoted to head nurse, because they refuse to do certain things. I think this is wrong.

When a nurse is being interviewed for a hospital job, she is asked, "Are you willing to assist a doctor in euthanasia cases?" If she says, "No", she will not be offered the job. I think that is wrong.

Nurses still have requests that have not been fulfilled. For example, they are not yet part of the decision-making process. They participate in decision-making only when doctors allow them to take part. Otherwise, they cannot express their opinions. Many nurses feel they want to talk about it and need to talk about it, but there is nobody to talk to.

*Vlaming 21:69*

In response to a question about how many nurses in Holland are pro-euthanasia or anti-euthanasia she replied as follows:

**Mrs. Vlaming:** We have no figures on that, but there are only a few nurses who really object to being involved in euthanasia.

**Dr. van der Wal:** Some hospitals and nursing homes of a religious affiliation in the Netherlands have a policy as stated by Mrs. Vlaming. However, it is incidental, in my opinion, because it is forbidden for nurses to assist in the performance of euthanasia. It is forbidden for nurses to have a real say in the decision-making process about euthanasia and assisted suicide.

It is impossible for the management of a hospital or a nursing home to erect a career barrier for a nurse. They can ask a nurse beforehand if she has objections to euthanasia or assisted suicide. If they are prepared when they receive a request from a patient, they can give that information to the doctor or refer it to another nurse. Like doctors, it can be asked of nurses as well.

**Mrs. Vlaming:** I do not agree.

*21:70-71*

When Mrs. Vlaming was asked to expand on what the nurses felt were the main issues regarding euthanasia she responded:

Mrs. Vlaming: The main problems for the nurses are a result of not properly defining euthanasia. We have been working with the nurses to educate them about when they should speak about euthanasia and when they should not. They feel the same as you do when treatment is withheld, or when passive euthanasia occurs. They refer to everything as euthanasia, so it is difficult. Often, they have the idea that they are euthanizing people when they are not. Approximately five or six times a week they call the bureau and say, "Can I do this? Can I do that? Is it my duty to euthanize these people?" There is no end to their questions.

The issues that we are talking about today will be of interest to the nurses in Holland also because after two years they think that they know all about it, but they do not. Emotionally, they cannot deal with euthanasia. That is the problem.

*Vlaming 21:23*

### **1.3 The Nursing Home System**

The nursing home physician is a member of a distinct medical specialty, with its own licensing authorities and a separate training regime of approximately three years after a doctor has received his basic qualifications.<sup>83</sup>

[As has been said], we have about 300 nursing homes, comprised of 50,000 beds and about 700 nursing home doctors. A quick calculation will tell you that each nursing home has an average of two or three doctors and 100 to 300 beds. In each nursing home, there are about 50 to 150 nurses, as well as nursing assistants.

With regard to control, social control in the nursing homes is very high. The heart of the care there is done by nurses. Rooms in nursing homes accommodate two, four, or six patients, so there is a built-in element of control there. There are some single rooms, in particular for the very ill. I believe that is almost impossible for nursing home doctors to terminate the lives of patients who did not request it.

*van der Wal 21:37*

### **1.4 Pain Control and Palliative Care**

A number of witnesses before the committee suggested that the Dutch approach to euthanasia had resulted in the underdevelopment of palliative care and hospices on the British model. Alternatively, they suggested that the demand for euthanasia in the Netherlands resulted from deficiencies in palliative care treatment. A majority of the Dutch themselves feel that these are both characterizations of the situation are inaccurate.

The government summary of the Rummelink Report refers to the importance of terminal, or palliative care:

By terminal care, the commission means the whole of assistance and care on behalf of dying humans and their next of kin. Optimal care for someone dying implies that the doctor has knowledge of adequate treatment for pain, of alternatives for the treatment of complaints about

unbearable pain and awareness of the moment at which he must allow the process of dying to run its natural course.<sup>84</sup>

During the video-conference, Dr. Heintz suggested that the number of patients who actually receive euthanasia is fairly low, notwithstanding its availability, indicates a high standard of palliative care both in the hospital and in the home situation.<sup>85</sup> The number of cancer patients who have euthanasia or assisted suicide in the Netherlands is in the range of 5 per cent, which is compatible with what the Committee was told about the percentage of patients in Canada whose pain cannot be controlled.<sup>86</sup>

At the heart of the Dutch approach to end-of-life issues is the question of autonomy and personal choice. When the House of Lords Select Committee on Medical Ethics visited the Netherlands to discuss the issue of euthanasia, the Deputy Head of the Medical Ethics Section of the Dutch Ministry of Welfare, Health and Culture, observed:

Dame Cicely Saunders [the head of the British hospice movement] had said that she would, if necessary, render patients into a state of pharmaceutical oblivion, but that for many this was not an acceptable condition. People who did not share Dame Cicely's Christian belief might prefer not to die in such a condition, but to choose euthanasia instead.<sup>87</sup>

While the Dutch do not have the British system of hospices, it is a deliberate policy rather than a sign of neglect. The Dutch system believe in bringing palliative care to the patient rather than the patient to palliative care.<sup>88</sup> On the whole it integrates palliative care into other aspects of the health care infrastructure. For example, a system of Comprehensive Cancer Centres covers the whole country. At these centres, health care organizations, hospitals, GPs and nursing homes can obtain advice or consultation from all the cancer specialists, including the palliative care specialists.<sup>89</sup>

As Dr. van Delden noted during the videoconference:

We do not have separate palliative care facilities in general. There are some facilities, but that is not the major way in which we deal with this. Palliative care is integrated into other existing forms of health care. Hence, it is integrated into the hospital. A central part is played by our nursing homes. Also, the general physician plays a central role in palliative care.

*van Delden 21:28*

Some physicians who are opposed to euthanasia agree that palliative care must be approached differently in the Netherlands. As Dr. Zbigniew Zylicz, the founder and medical director of the Hospice Rosenheuvel, notes:

In Britain, there is more of a tradition of hospitalization, of institutionalization for dying. It is different here. Dutch people are used to dying at home. In Holland, statistics show that 42 per cent of patients die at home, with fully available home nursing care, compared to only about 20 per cent in Canada and Britain. . . . To create more institutions will not help. We do not

84 The Netherlands, Ministry of Welfare, Health and Culture, "Medical Practice with Regard to Euthanasia and Related Medical Decisions in the Netherlands: Results of an Inquiry and the Government View", VDB 92-034, p. 8.

85 Heintz 21:17

86 van Delden 21:24

87 House of Lords, *op. cit.*, p. 67.

88 van Delden, "Euthanasia in the Netherlands", p. 24.

89 Heintz 21:28



need here in Holland 40 or 50 hospices. We need a new way of thinking. What we need here is 30 to 50 consultants on palliative care who can work with the doctors in the community, visit patients in their homes. We need university training programs to teach the advanced methods of pain and symptom control<sup>90</sup>

Other physicians who are opposed to euthanasia believe that there is a need for more palliative medicine in Holland but that it has been hindered because of economic motives. Dr. Karl Gunning, a Dutch physician whose testimony the committee heard before the video-conference, commented:

You have heard all kinds of testimony about palliative medicine, something which we in Holland are trying to introduce. However, we are not receiving the support of the government, even though it has received a report from a committee which it initiated that states that pain treatment, when sufficient, is a solution to the problem. Why did the Dutch government not solve the problem by dealing with pain? Why did it have to introduce euthanasia? Why did it have to legalize it? I suspect that there are strong economic motives behind it.

Gunning 17:91

### 1.5 What the Doctors Say

Dr. Dirkjan Bakker was the only participant in the video conference who stated that he was against euthanasia for personal reasons:

My religious belief forbids me to perform euthanasia. On the other hand, I am a member of the Royal Dutch Medical Association and a member of the small group of physicians who are opposed to performing active euthanasia.

That group of doctors has some concerns about the act of euthanasia. Because the law, which does not permit euthanasia but facilitates performing it under certain circumstances, is evolving, we are afraid of the slippery slope...

Our concern is that if you have a very strict definition of euthanasia, not many patients or doctors will fulfil that criteria and the grey zone will be very large. Our concern is that the grey zone can be enlarged and when the possibility of performing euthanasia on request is widened, again the slippery slope will come into play.

At the moment, there is a lot of discussion about active euthanasia. We are free either to perform it or not to perform it. Legislation is made for the future. Future generations will not have had these extensive discussions around the problems concerning end-of-life matters. When exceptions are made more in the direction of the rule, then exceptions become the rules and rules — not to perform active euthanasia — may be exceptions in the future. That is our concern.

To be honest, a very small minority of people in the Netherlands is opposed to performing active euthanasia.

Bakker 21:36-37

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90 Mullens, "A place where euthanasia is talked about, but not offered, in *Euthanasia, op. cit.*, pp. 33-34

The Committee was also told that, for those physicians who will perform euthanasia, it is always a difficult act.

I know doctors have done it ten times, and the tenth time it is with as much difficulty as the first. It is done on the request of the patient, and it is because the patient is suffering, but it is still very difficult for a doctor. That is my experience.

*Leenen 21:67-68*

When the Dutch panel was asked if physicians ever said "Never again" after performing euthanasia, one replied:

I was one of them. The first time I performed euthanasia, I said that I would never do it again. One of my patients then asked me to do it for him, and I decided that I could not refuse him, no matter how I felt. I had known him for almost ten years. I also knew his wife and family.

*De Heer 21:68*

## 2. The Legal Situation

One of the participants in the video-conference was Professor Leo Meijers, the Advocate General, Supreme Court of the Netherlands, who described his role as an independent scientific advisor of the Supreme Court. Another was Mr. Eugene Sutorius, a defense counsel specializing for the last ten years in Dutch law on euthanasia, a deputy judge in the Court of Appeal in Amsterdam and a member of the Ethics Committee of the Royal Dutch Medical Association.

As Mr. Sutorius pointed out during the video-conference,

the concepts that [Canadians] use in [their] criminal law system are quite different from [the Dutch] continental system, which is derived from Roman law.

*Sutorius 21:29*

Trial by jury, for example, is unknown in the Netherlands. Procedures for the administration of justice are mainly embodied in the *Code of Civil Procedure* and the *Code of Criminal Procedure*, although provisions relating to administrative procedure are found in a variety of statutes. Sixty-two cantonal and 19 district courts are courts of first instance. From district courts, appeals lie to five regional Courts of Appeal and then to the Supreme Court. All judicial appointments are made by the Crown.

The Supreme Court at the Hague has several divisions, each consisting of five judges headed by an advocate-general for a total of 24 justices. Known as the Court of Cassation (the power to quash), the Supreme Court hears appeals involving procedural errors or mistakes of law. If the Supreme Court allows an appeal on a point of law, it may be necessary to send the case back to a trial court to review how the facts of the case relate to the law as restated by the Supreme Court. The lower courts are autonomous and not bound by Supreme Court decisions. However, if they do not follow the legal principles established by the Supreme Court, their decisions will naturally be appealed to the Supreme Court. Hence, they tend to follow the precedents established by the Supreme Court even though not legally bound to do so.<sup>91</sup>

Criminal proceedings may be instituted only by the Department of Public Prosecutions. It is composed of the Advocate-General, the Solicitor-General and the advocates general at the Supreme Court; five attorneys-general, advocates-general and solicitors-general at the courts of appeal; 19 chief public

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91 Leenen 21:33.

prosecutors, and traffic magistrates attached to district and cantonal courts for a total of 250. The department is structured hierarchically in the same manner as the judicial system. The Advocate-General is independent and is appointed for life. He is consulted by the Supreme Court in all cases brought before it and may initiate an appeal “in the interests of law” on his own initiative.<sup>92</sup>

The Department of Public Prosecutions has considerable independence. Dutch law recognizes the principle of opportunism as opposed to the principle of legality. This means that a public prosecutor is not bound to prosecute except on the express order of a court of appeal, the minister of justice or the procurator general. Mr. Sutorius emphasized the importance of the prosecutor’s role in Holland:

He can drop a case on what we call the “opportunity principal” on grounds that are in the public interest, which gives him a discretionary freedom. That is why, in the end, the Minister of Justice has political responsibility for it and has to decide whether or not he will prosecute a case.

Sutorius 21:39

It is this discretion on the part of the individual prosecutor and, ultimately, on the part of the Minister of Justice, that permits the unique Dutch approach to euthanasia and assisted suicide. Although both acts remain illegal under the *Criminal Code*, it is universally understood that no prosecutions will be initiated if certain conditions are met. In Canada, prosecutors have considerable discretion as to whether or not to initiate a prosecution depending upon their assessment of the likelihood of a conviction, but none to refuse a prosecution on “public interest” grounds where they are convinced that a criminal act has taken place and is provable. As well, with certain specific exemptions, criminal prosecutions are initiated by provincial prosecutors, and the imposition of national guidelines would be extremely difficult.

### 2.1 Definitions

As Mr. Sutorius pointed out during the video-conference, “it is not easy to translate [Dutch] concepts into proper and meaningful definitions which [Canadians] would understand”<sup>93</sup>, and this leads to numerous misunderstandings and misinterpretations of the Dutch situation.

Euthanasia is defined as a criminal offence under Article 293 of the Netherlands *Criminal Code*: “Anyone who takes the life of another person at that other’s express and serious request, will be punished with a prison sentence of a maximum of twelve years, or a category five fine.”

Assistance in committing suicide is defined as a criminal offence under Article 294 of the Netherlands *Criminal Code*: “Anyone who deliberately incites another to commit suicide, assists him in so doing or provides the means for him so to do will, if suicide follows, be punished with a prison sentence of a maximum of three years, or a category four fine.”

Three important points are implied by these definitions. Firstly, euthanasia and assisted suicide are acts; they are defined as doing something, usually handing over or administering a drug. They are not defined as refraining from action — that is, not starting or stopping a treatment (not even by the action of changing the switch of a ventilator). Secondly, euthanasia and assisted suicide are defined as voluntary (at request), thereby excluding particular patients, such as newborn infants or comatose patients. Thirdly, the term “intentionally” is usually interpreted as “with the primary intention of”. Thus the treatment of pain, for example by high doses of

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92 George Thomas Kurian, *Encyclopedia of the First World*, Vol. II, pp. 775-6;

93 Sutorius 21:39

morphine, with the secondary effect of shortening the life span, is not considered to be euthanasia.<sup>94</sup>

Although assisted suicide and euthanasia have different legal consequences, a moral distinction between the two acts is not usually made in the Netherlands. In both cases, the physician has to comply with same procedural and substantive requirements.<sup>95</sup>

Finally, article 40 of the *Code* states: "It is a defence to a criminal charge if the accused was compelled to action by *overmacht*." The defence of *overmacht* was described by Dr. Gerrit van der Wal during the video-conference:

The legal basis of this verdict is the force majeure wherein the physician must act. The doctor is confronted with conflicting obligations: towards the patient, as a caregiver; and towards the law, as a civilian. Professional obligations force the doctors to act against the formal provisions of the law, but in accordance with viewpoints developed in medical ethics and with the explicit wish of the patient who relies on him or her.

van der Wal 21:9

As Professor H.J.J. Leenen, Professor Emeritus of Social Medicine and Health Law, pointed out, the term *force majeure* is a concept used in civil, or private, law in North America, but not in criminal law. Therefore, he suggested that it would be better to use the term "necessity", a concept familiar to the Canadian criminal law.<sup>96</sup>

A recent paper on the defence of necessity describes the common-law situation as follows:

In theory, then, the defence of necessity is not precluded when the accused is charged with what in effect amounts to a mercy-killing, even when ... the deceased did not consent to the act. However, even if the accused is a physician and the deceased his patient who had pleaded for a lethal injection to end his misery, the public policy of the common law is that the defence of necessity cannot be allowed to undermine the prohibition against active voluntary euthanasia (or for that matter, physician-assisted suicide). In fact, in none of the small handful of mercy-killing cases against physicians has the accused even raised a necessity defence.

The policy is illustrated by the unreported 1992 English case of *R. v. Cox*, in which the accused-physician was charged with attempted murder after he gave a lethal dose of potassium chloride to a 70-year-old patient who had begged him to end her life. The patient was dying of rheumatoid arthritis, complicated by gastric ulcers, gangrene and body sores; and near-fatal doses of heroin were unable to relieve her agony. (The reason that Dr. Cox was not charged with murder was that the patient was so near death that the pathologist could not prove that the injection of potassium chloride had caused the death).

Still, the accused did not seek to excuse his act on the grounds of (medical) necessity... The accused was therefore left without a defence to the charge, and the trial judge accordingly instructed the jury that the evidence of guilt was overwhelming and that it had no option but to convict. The jury complied, although a number were in tears when the verdict was announced. Dr. Cox received a one year suspended sentence, and although reprimanded by the General Medical Council he was not stricken from the medical roles.

94 Gerrit van der Wal and Robert J.M. Dillman, "Euthanasia in the Netherlands," *British Medical Journal* 1994; 308: 1346, at 1346.

95 Professor J. Legemaate, "Legal Aspects of Euthanasia and Assisted Suicide in the Netherlands 1973-94", a paper presented at the Euroconference on euthanasia and assisted suicide, Maastricht, June 10-11, 1994, p. 1 (to be published in the *Cambridge Quarterly of Healthcare Ethics*).

96 Leenen 21:14, The defence of necessity arose in Canada during the recent Latimer case.



In sum, although the defence of medical necessity has been recognized in abortion cases, the Cox case illustrates the unwritten common law rule that it is not available in euthanasia cases. In the Netherlands, on the other hand, the judiciary has carved out what amounts to a defence of medical necessity in cases involving physicians who either give lethal injections to or assist the suicide of consenting patients.<sup>97</sup>

Another term used to describe the defence of necessity is *noedtoestand*, which is technically translated as “situation of necessity”. “However, in the case of euthanasia the “necessity” which has been recognized by the Dutch courts is not a general necessity but specifically a medical necessity, measured in terms of the state of medical knowledge and the professional norms of doctors, and it seems clear that no one but a doctor can successfully invoke it.”<sup>98</sup> In brief, the Dutch defence of *noedtoestand* recognizes a situation in which a doctor is faced with a situation of emergency, and committing a crime is considered a lesser evil than adhering to the letter of the law. There is no reasonable alternative to breaking the law because the intent of the doctor is to relieve suffering and there is no alternative method.<sup>99</sup>

## 2.2 Judicial Interpretations

Starting with the Postma case in 1973, a series of prosecutions against physicians accused of euthanasia or assisted suicide resulted in judicial and medical guidelines outlining the circumstances in which such acts would be acceptable in the Netherlands. In the Postma case, a doctor was found guilty of giving her 79 year-old mother a lethal injection after repeated requests to end her suffering. Although she was placed on probation for a year, the facts of the Postma case resulted in considerable sympathy for the doctor, and resulted in the Royal Dutch Medical Association (KNMG) producing a working paper on the subject. As well, the Court set out a number of conditions that would have to be met before an accused would be exonerated of euthanasia.

In 1984, two separate events accelerated the evolution of euthanasia policy in the Netherlands. First, the KNMG published a policy position on euthanasia in its official journal. Second, the Supreme Court accepted, in the Schoonheim case, that a physician could be acquitted of euthanasia when faced with an irreconcilable conflict between (1) his duty to abide by the law and (2) his duty to relieve a patient’s suffering by ending a life of unbearable and irreversible suffering. Dr. Schoonheim had euthanized a 95-year-old patient who was mentally unimpaired but suffering continuous physical degeneration. Since she had become bed-ridden in a nursing home, she had consistently asked to die. “By the last week of her life, she could no longer take liquids nor speak and was suffering periodic lapses of consciousness. However, she did regain some ability to speak and expressed her horror at the fact that she was still living. She then begged her son to help her to fulfil her repeated requests to die.”<sup>100</sup> After discussions with the patient, the family and a young colleague, Dr. Schoonheim finally agreed to terminate her life. The next year, a district court, following the guidelines in Schoonheim, acquitted Dr. Admiral in the death of a 34-year-old multiple sclerosis patient who, although totally paralysed and suffering intractable pain, was not in danger of imminent death.

As with the Canadian judicial system, the Dutch prosecutorial system is not without flaws. The *der Terp* case, in which a doctor had killed a number of patients in a nursing home, resulted in an acquittal. This has been interpreted in a number of articles as an indictment of the Dutch approach to euthanasia, and a confirmation that the “slippery slope” exists.

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97 Sneiderman and Verhoef, pp. 6-9

98 John Griffiths, University of Groningen, Faculty of Law, unpublished paper, p. 1.

99 Barney Sneiderman, “Euthanasia: Law Reform and Social Policy”, in *Euthanasia in the Netherlands: A Model for Canada*, p. 9.

100 Sneiderman and Verhoef, p. 14.

One case which is always cited in international literature is the *der Terp* case in which a doctor, without request in accordance to the rules, killed some patients in a nursing home. That is the case to which Professor Legemaate referred. In that case, the prosecution erred. It brought before the court files which were not admissible because of medical secrecy. The court had to dismiss the case, not because they accepted the actions of the doctor, but because the requirements of law were not met.

*Leenen 21:35*

### 2.3 Political and Legislative Response

Following the 1984 Supreme Court decision there were various attempts to legislate on the subject of euthanasia. In 1986, 1987 and 1993, Bills were introduced which would have set out criteria for euthanasia in either the *Penal Code* or the *Medical Practice Act*. None of these bills succeeded.<sup>101</sup>

At the beginning of 1988, there were two draft laws on euthanasia before Parliament. After the general elections in 1989, a new coalition government was formed, which decided that any legislation on euthanasia should be preceded by a national investigation.

In January 1990, a commission of inquiry into medical practice with regard to euthanasia (the Rummelink commission) was set up by the Minister of Justice and the State Secretary of Welfare, Health and Culture. An independent investigatory team, led by Professor P.J. van der Maas, was contracted to conduct a wide-ranging study of the existing situation. To encourage the cooperation of the Royal Dutch Medical Society, the Ministry of Justice guaranteed legal immunity to participating physicians, and agreed on a notification procedure to be used in cases of euthanasia and assisted suicide:

The doctor does not issue a declaration of a natural death; the doctor informs the medical examiner by means of an extensive questionnaire; and the medical examiner reports to the public prosecutor who decides whether a prosecution must be started.<sup>102</sup>

The aim of the notification procedures was to harmonize prosecution policies in the various regions of the country, and to eliminate certain investigative practices, such as the interrogation of relatives within hours of death, that had discouraged physicians from reporting cases.<sup>103</sup>

Following the recommendations of the Rummelink committee, which reported in September 1991, the government introduced a Bill to give legislative force to the voluntary 1990 guidelines. As recommended by the Commission, the reporting procedure was extended to include "active interference by a doctor within the scope of care for the dying without an explicit request from the patient, apart from those situations in which the vital functions have already and irreversibly begun to fail."<sup>104</sup>

In recent articles, officials of the Royal Dutch Medical Association have criticized this extension of the reporting procedures, arguing that it creates the false impression that the ending of life without an explicit request can be as acceptable as euthanasia and assisted suicide. Whereas euthanasia and assisted suicide respect the crucial role of self-determination, ending a patient's life without a request raises far more difficult questions of legitimacy.<sup>105</sup>

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101 House of Lords, *op. cit.*, p. 65

102 van der Wal and Dillman (1994), p. 1347.

103 Legemaate (1994), p.5.

104 The Netherlands, Ministry of Welfare, Health and Cultural Affairs, "Medical Practice with Regard to Euthanasia and Related Medical Decisions in the Netherlands: Results of an Inquiry and the Government View", VDB 92-034, p. 7.

The new law, Bill 22572, came into force on June 1, 1994. It did not amend the *Penal Code*, and euthanasia remains a criminal offence. Instead, the *Burial Act* 1955 (Act on the Disposal of the Dead) was amended to specify the required reporting procedure. Where the correct procedure is followed, and the specified criteria fulfilled, a policy of non-prosecution prevails. On the other hand, reporting is now mandatory and a physician who does not comply can be prosecuted.

A physician... must state when there is an unnatural death involved and the notification procedure must be followed. Only if an improper statement concerning the causes of death is given can a physician bypass the notification procedure. In effect, it is mandatory.

*Dillman 21:56*

To come within the provisions on assisted suicide and euthanasia of the *Burial Act*, a physician must complete a full written report based upon a lengthy questionnaire, and submit it to the municipal coroner who forwards it to the local public prosecutor. The prosecutor reviews each case in light of the legislation and existing jurisprudence. All such decisions are reviewed at regular meetings of the solicitors-general for each of the five appeal courts. Ultimate political responsibility for all decisions not to prosecute rests with the Minister of Justice.<sup>106</sup>

Aside from requiring a case history, the questionnaire asks whether the patient made a request “freely, quite explicitly and on a well-considered and permanent basis”. Additionally, the physician must describe when and to whom the request was first made and repeated; whether a written declaration of will (advance directive) was available; the evidence showing that the patient was fully aware of the import of the request and of his/her physical condition; and whether the views of the next of kin were requested or why they were not consulted. If the patient has a psychiatric disorder, additional information is required, such as whether any medical or therapeutic alternatives were available and the evidence showing that the patient rejected these alternatives.

In a case where there was no explicit request, the physician must explain why this was so, whether there was any other communication by the patient concerning the termination of life, who first raised the question of termination, and at what point. The physician must describe any other considerations which determined the medical decision and the timing of the intervention.<sup>107</sup>

The criteria that emerged from court decisions and professional guidelines are both substantial and procedural:

### Substantive guidelines

- the request for euthanasia must come from the patient and be entirely voluntary, well-considered and persistent;
- the patient must have adequate information about his medical condition, the prognosis and alternate treatments;
- there must be intolerable suffering with no prospect of improvement, although the patient need not be terminally ill;
- other alternatives to alleviate the suffering must have been considered and found ineffective, unreasonable or not acceptable to the patient;

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105 Legemaate (1994), p. 9; van der Wal and Dillman (1994), p. 1348.

106 House of Lords, *op. cit.*, p. 64

107 Decree of 17 December 1993, Ministry of Justice.

### Procedural guidelines

- euthanasia must be performed by a physician who has consulted an independent colleague;
- the physician must exercise due care, and there should be a written record of the case; and
- the death must not be reported to the medical examiner as a natural death.<sup>108</sup>

These are the formal requirements, but there are also other informal or local resources of which physicians either can or must avail themselves.

By example, ... the practising physician can go to the state inspector of health for guidance. Alternatively, he can go to the Royal Dutch Medical Association, the local district attorney, or the medical examiner for guidance. In many districts of the country, it is the rule that 24 hours before euthanasia takes place, the physician must consult the medical examiner who functions as a go-between on behalf of the physician between the medical system and the legal system.

*Dillman 21:16*

Even where a physician is not prosecuted under the *Criminal Code*, he or she could be found guilty of bad medical practice by a medical disciplinary court. In the Netherlands, these are not just disciplinary bodies but legal courts regulated by law.<sup>109</sup> During the video-conference, Mr. Sutorius pointed out that there have been several cases where a physician had to undergo both criminal proceedings and disciplinary court proceedings.

After 10 years, there have been nine or ten cases in the criminal court sphere and five or six disciplinary court rulings. By and large, the rulings are harmonious.

In the Chabot case, it may be interesting for you to know that our inspector for public health initiated a complaint in his own right, after our Supreme Court declared Chabot guilty without punishing him. That case will now be tried before a disciplinary court, a fact which does not please Dr. Chabot because already there have been years of sessions in this matter. Nevertheless, it happens.

That may be an indication of the unrest which has originated in society because of this case.

*Sutorius 21:61*

The Dutch panel during the video-conference seemed to be strongly of the opinion that it was preferable to have legislative action than “judge-made law”. While the political situation in the Netherlands makes a legislated solution difficult, if not impossible, there was general agreement between the Dutch panel and the Canadian Senate committee that the issue was best dealt with by politicians rather than the courts.

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108 Sutorius 21:42

109 Leenan 21:64



We have a problem [in the Netherlands] in that we are a multi-opinionated society. Christian Democrats are against euthanasia. Catholics are mostly in favour of euthanasia. Yet, officially, the Episcopates, Roman Catholics, and the Christian Democratic Party are opposed to euthanasia. They generally hold one-third of the seats in Parliament. Until the last half-century, the Christian Democrats always formed the government and they refused to legislate euthanasia. The Parliament was incapacitated to legislate. The only way it was possible was because of the Supreme Court jurisprudence.

*Leenen 21:52*

## 2.4 Psychological or Mental Suffering

There have been several recent cases in the Netherlands involving physicians who assisted a suicide brought about by psychiatric or mental suffering. In the Netherlands, and in the testimony heard by the Committee, this has been the most controversial development of Dutch policy. Mr. Sutorius summarized the present legal situation as follows:

In Holland, we finally agreed that suffering is always mental, even if it has a somatic [physical] source. Suffering is a mental process.

We also agreed that psychiatric suffering is much less physical, and the possibility of alternatives is more difficult to exclude. Everyone agreed in Holland that we should not take the same route as we did with somatological suffering.

The Supreme Court found itself caught in the principle of equality... It was clear that suffering can be as exhaustive and unbearable when it has psychiatric roots, as when it is caused by terminal cancer. There was no reason to exclude those categories of sufferers requesting death. ...

It is important to note that our Supreme Court agreed that there should be no distinction made between suffering from a psychiatric disease or a somatological condition. Also, when we talk about psychiatry, no distinction is to be made between whether it is a disease or a trauma.

*Sutorius 21:52-53*

However, the process of arriving at these conclusions was neither easy nor uncontroversial. In 1990, Dr. Kors, a paediatrician, assisted in the suicide of a 25-year-old anorexic, Maria S. Dr. Kors had been treating her since 1974, when she was eight-years-old. Despite aggressive therapy, Maria did not improve. In May 1990, her younger brother committed suicide by asphyxiation, and Maria announced at his funeral that she intended to do the same. Maria had previously asked Dr. Kors to assist her suicide, but after her brother's funeral she refused further tube feeding or hospitalization. She weighed 19 kilos, and was continually afflicted with vomiting and severe stomach pains. A psychiatrist who had previously seen Maria met with her again, and gave his opinion that she was mentally competent and that there were no treatment options to ease her mental suffering. Dr. Kors provided a lethal dose of seco-barbital, which Maria took five days after making a video explaining her desire to die.

When Dr. Kors was charged with assisting a suicide, his attorney, Mr. Sutorius, argued that a provision in the constitution of the Netherlands guaranteeing "equality before the law" prevented restricting euthanasia or assisted suicide to patients with somatic-based suffering or physical illness.

Given that the issue is whether the patient's suffering is unbearable and beyond remedy, it is pointless to inquire as to the source of his misery. What counts is the suffering, not from whence it has sprung. After all, if the patient is afflicted with cancer, multiple sclerosis, or a non-diseased body encased in a tortured soul, suffering is a mental process whose magnitude is not conditioned upon its origin in the body or the mind. In either case, the patient can experience

her continued existence as a living hell with no way out except the merciful release of death. Furthermore, since the euthanasia policy is buttressed by the twin pillars of beneficence and autonomy, the mentally competent patient whose suffering is non-somatic surely qualifies as much as her counterpart whose suffering stems from a physical disease process. In either case, the resort to euthanasia is a beneficent act because it enables the patient to end a life whose burdens have overwhelmed its benefits...

The Court was satisfied from the evidence that the medico-legal guidelines had been satisfied: that the patient was free of psychosis and was mentally competent; that her wish to die was well considered and persistent, and that it was a product of her free will; that her suffering was relentless and intolerable; and that there were no reasonable treatment regimes to ameliorate her condition.<sup>110</sup>

In another case that commenced with a death in 1985, but did not legally terminate until 1994, Dr. Duintjer, a psychiatrist, was charged with assisting the suicide of a 50-year-old patient. Martha N. was married and had two adult children, but also a 25 year history of depression and alcohol abuse. During the last years of her life, she experienced unbearable bouts of depression and engaged in several attempts at suicide. In 1983, she drank a household cleanser which damaged her vocal chords; in 1984 she set herself on fire and a few months later jumped out a second story window; and in 1985 she took an overdose of sedatives obtained by falsifying a prescription. She had made repeated requests of both Dr. Duintjer and her family physician for assistance in committing suicide.

By [1985], Dr. Duintjer was prepared to accept that there were no treatment modalities that could ease her distress. It was clear that she desperately wanted to die, not only for her own sake but also to put an end to the constant stress that her condition imposed upon her family. Furthermore, she had a clear understanding of her situation and was mentally competent to ask for medical assistance to end her life.<sup>111</sup>

The doctors also involved her pastor in the case, and after a dozen meetings he too was of the view the that case was hopeless, and that the physicians were entitled to assist her in her determined attempts to die. Although the prosecution was complicated by various technical matters, the court rejected the argument that psychiatric patients were by definition incompetent to qualify for euthanasia.

The most recent and most publicized case, Chabot, concerned Hilly Boscher, a 50 year-old-social worker devoted to her two sons. The first committed suicide after a broken love affair, and four years later the younger son was stricken with cancer. On the day he died, she attempted suicide. After unsuccessful attempts to obtain a lethal dose of drugs, she contacted the Dutch Society of Voluntary Euthanasia who put her in contact with Dr. Chabot.

As an experienced and well respected psychiatrist, Dr. Chabot took particular gratification from the many cases in which he had helped suicidal patients find reason to get on with their life. At their first session, she was quite insistent that her continued existence was intolerable.

Although adamant that life held no prospects for her, she did agree to enter into an ongoing therapeutic relationship with Dr. Chabot. At his suggestion, she also kept a journal which she shared with him. What emerged from the therapy sessions and her writings was an unwavering determination to die.

As indicated, she refused anti-depressants as well as "bereavement therapy". Hilly told Dr. Chabot that she simply was not prepared to undertake the commitment to work with him to

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110 Snederman and Verhoef, 21-22.

111 *Ibid.*

change her bleak outlook on life. She was who she was and she could not envision becoming a different person.

On August 30, she told him that she had some sedatives and asked whether the dosage would be lethal if swallowed with alcohol. When he said that he thought not, she beseeched him to provide her with a prescription for Vesperax [a potent barbiturate-based sleeping pill] and that she would have it filled at various pharmacies until she had enough to end her life. He replied, "If I help someone to die, it will not be in secret."

After Dr. Chabot reported the case to the authorities, he wrote a letter to a Dutch psychiatric journal, in which he stated: I do not know whether I did the right thing... but I do believe I chose the lesser of two evils. We can no longer avoid the question of whether, in certain circumstances, people should be allowed to die at a time and in a manner that they feel appropriate.<sup>112</sup>

After seven experienced colleagues had reviewed the transcript of the therapy sessions and concluded that it was a hopeless case, Dr. Chabot concluded that the lesser evil was to provide her with the means to commit suicide painlessly and with as little violence as possible. At his trial, Dr. Chabot testified that there was no question of a psychiatric illness or a major depressive disorder.

Although the patient was suffering from neither a physical nor mental illness, Attorney Sutorius argued that the case fit squarely within the medico-ethical principles of self-determination (autonomy) and mercy (beneficence) that are the twin pillars of the Dutch euthanasia policy. Regarding the former, he argued that respect for the person outweighs the duty to preserve life; and regarding the latter that the relief of unbearable and irremedial suffering likewise outweighs the duty to preserve life.<sup>113</sup>

The Supreme Court accepted the principle that mental suffering could be sufficient to justify assisted suicide, but added a number of cautionary notes. In the event, it reversed Dr. Chabot's acquittal, and entered a conviction, on the grounds that none of the consulting psychiatrists had personally examined the patient. Under the circumstances, the court waived any punishment, the equivalent of an absolute or conditional discharge in Canada.

During the video-conference, Dr. Leenen noted four salient features about the Chabot decision. First, although there was some debate as to whether or not the lady was a psychiatric patient, the court decided that even a psychiatric patient could be competent to request assisted suicide. Second, people who are not psychiatric patients but are suffering severe and intractable mental pain have the same right. Third, particular care must be taken to fulfil the strict letter of the guidelines, including a personal examination by a second consultant, when non-somatic or mental suffering is involved. Fourth, the court confirmed that imminent death was not necessary for the defence of necessity to be available.<sup>114</sup>

Dr. Leenen emphasized that psychiatric patients, or persons who are not patients but are suffering severely, present a particularly difficult problem. In 1993, the Royal Dutch Medical Society released a report emphasizing the difficulty in determining whether or not a psychiatric patient can deal with such an important decision.

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112 *Ibid.* pp. 27-31.

113 *Ibid.* p.31.

114 Leenen 21:47-49



In my opinion, and in that of Mr. Meijers and the state committee, it is possible, but you have to be very careful because if the wish to end life results from psychiatric disease, then you have to treat the disease and not end the life. It is always difficult to assess. Nevertheless, the Supreme Court did not exclude that fact, but rather mentioned three times in the decision that it was very important to be cautious. Such a warning is rather exceptional from the Supreme Court to the doctors.

*Leenen 21:48*

In response to a question about the prevalence of depression in dying patients, Dr. Heintz noted that depression at the end of life is very common. In the Netherlands, when it occurs in a hospital situation a psychiatrist is always asked for a consultation. If it can be treated, and the patient accepts the treatment, that is the preferred response.

The diagnosis and treatment of depression is an essential part of adequate terminal care. In that respect, we treat those patients also, but not every patient wants treatment. The final wish of the patient is something that comes first.

*Heintz 21:17*

However, where a psychiatric patient is involved, the concept of available alternative treatment and the right to refuse treatment becomes much more complex. As Professor Leenen pointed out, a psychiatric patient is unlikely to be allowed to refuse treatment, and this is an important deviation from the normal rules of consent. Such patients have to accept treatment if the treatment is available, unless it is unreasonable under all of the circumstances to expect them to consent.<sup>115</sup> Where the patient's suffering has a physical cause, a competent refusal of treatment ends the issue of possible alternative treatment because the patient cannot be treated against his or her will. However, with psychiatric patients and patients who are mentally suffering, a refusal of a realistic alternative treatment will likely disqualify the patient from receiving assisted suicide.

The holdings of the Supreme Court in Chabot can be summarized as follows:

1. Assistance with suicide can be legally justifiable in the case of a patient whose suffering does not have a somatic base and who is not in the terminal phase.
2. A person suffering from a psychiatric sickness or disorder can still express a wish to die that is legally the result of an autonomous (competent and voluntary) judgement.
3. However, the suffering of such a person, in principle, cannot be considered "lacking any prospect for improvement" if he or she has refused a realistic therapeutic alternative.
4. In such a case, the legal requirements of consultation can only be met if an "independent colleague" of the physician assisting the suicide has personally examined the patient.<sup>116</sup>

Several participants in the video-conference noted that the Supreme Court did not seem comfortable dealing with the issue of assisted suicide to relieve mental suffering, and Mr. Sutorius concluded that:

Our Supreme Court followed the route they took in 1984, but at the same time they signalled to our society that this is the borderline and they did not wish to go further.

*Sutorius 21:53*

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115 Leenen 21:50

116 Griffiths, *op cit* 9.



From the testimony of a number of witnesses before the Committee it seemed clear that cases where a suicide was assisted to relieve mental or psychological suffering caused particular discomfort. Many groups and individuals seemed concerned with the suggestion that physicians involve themselves in the suicide of individuals who have neither a terminal illness nor a specifically physical source of suffering.

These cases have troubled many Dutch proponents of their Euthanasia policy, who express the sense that perhaps this is going too far. There is the sentiment that such a request should elicit the following message from the physician to the patient (however tactfully expressed). “I do not mock or deny your suffering. But if you are that unhappy, then exercise some initiative and find the way to kill yourself. After all, you can read Derek Humphrey’s best-seller, *Final Exit*, which will guide you to your death. Yet, do not turn to me for the answer. I am at your service, but this is where I draw the line — that it is not my role as a physician to provide lethal drugs as a permanent cure for unhappiness.”<sup>117</sup>

Many people think that from now on, after Chabot, it is easy for people who have psychiatric suffering, psychological suffering to get help to die. This is not so,” said Martine Corneliesse, co-ordinator of members’ services for the Netherlands Voluntary Euthanasia Association. “If anything, it is now more difficult,” she said. “Psychiatrists are very wary of this topic and the publicity of Chabot has made them even more wary. His decision was attacked in our most important mental health journal. In psychiatry, there is no support for it.”<sup>118</sup>

## **2.5 Other Aspects of the Law**

Because euthanasia must be requested by a competent person, severely defective newborns, comatose patients and patients with Alzheimer’s are not eligible for euthanasia. If a newborn has a severe condition which cannot be resolved, treatment can be withheld or stopped on the basis of futility. After long discussions with the family and medical team, there can be a cessation of medically futile treatment. If the baby, against expectations, does not die, and the pain cannot be relieved, it is a difficult situation.

From a legal point of view, again, [there is] the principle of necessity. The doctor’s duties are in conflict. The baby is suffering severely from unrelenting pain, yet the doctor is not allowed to terminate the life of that severely handicapped baby. The doctor can appeal, citing the necessity rule in our *Penal Code*, when he is unable to assist or relieve the pain. This happens in the Netherlands about four times a year.

*Leenen 21:18*

These occurrences are not euthanasia by Dutch standards, but individual cases of a conflict of duties wherein the discretion to prosecute may or may not be exercised. The Royal Dutch Medical Association provides ethical guidance to physicians facing such situations, but this does not affect the law.

The withdrawal of treatment for patients in a persistent vegetative state is legal because the treatment is medically pointless. Again, there are medical criteria that must be followed with respect to consultation and safeguards. Artificial feeding and nutrition is regarded as medical treatment, and the courts have upheld its withdrawal in the case of patient in a persistent vegetative state.<sup>119</sup>

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117 Sniderman, pp. 15-16

118 Mullens “The Dutch way of death”, in *Euthanasia*, *op. cit.*, p. 20.

119 Leenen 21:19, Sutorius 21:45.

It has not yet been clarified whether a person may request euthanasia by means of an advance directive or living will:

We have not yet had a case in which a physician performed euthanasia pursuant to a living will. Although there is currently no legislation in Holland endorsing the concept of patients' advance directives, we know that physicians are terminating life-prolonging treatment pursuant to such direction. Yet what about a living will requesting euthanasia in certain circumstances (e.g. a persistent vegetative state or advanced Alzheimer's disease)? My own view is that, if such a case arises, a court would likely rule that the physician acted properly provided that witnesses testify that the living will did in fact represent the views of the patient.<sup>120</sup>

Although family members or friends cannot request euthanasia on behalf of an incompetent patient, a person with an advance directive requesting euthanasia may nominate a personal delegate to interpret the advance directive.<sup>121</sup>

Although people from outside the country do inquire about the possibility of coming to Holland to receive either euthanasia or an assisted suicide, It is absolutely impossible to come to the Netherlands simply to receive euthanasia.

*Nieuwenkamp 21:31*

The Dutch approach evolved, in large part, out of the close and long-term physician-patient relationships that exist in the country and euthanasia will not take place in the absence of a very close physician-patient understanding.

### 3. The Data: the van der Maas study and the van der Wal study

#### 3.1 The van der Maas study

The report of the Rummelink Commission which was issued in September 1991, also contained the results of research carried out by the institute of Social Health Care of the Faculty of Medicine at Erasmus University in Rotterdam, with the cooperation of the Dutch Central Bureau of Statistics (the van der Maas study). In 1992, the van der Maas study was published in English in a special issue of *Health Policy*.<sup>122</sup> It is the data from this study that most subsequent commentators cite and, because of the controversial nature of the subject, the following sections contain exact quotes whenever it seems appropriate. However, it should be noted that some concerns have arisen about the translation, which has perhaps contributed to some of the controversy surrounding the Dutch experience.

Although the Rummelink commission was concerned with euthanasia, the van der Maas study had a wider scope. In Holland, euthanasia is limited to situations where there is an explicit and serious request, but the study chose to deal also with life-shortening acts where there was no explicit request (including withholding and withdrawal of treatment), and with the alleviation of pain or other symptoms where the shortening of life was a side effect (double effect).

The reasons for broadening the definition of the study were twofold: (1) there are divergent definitions of the concept of euthanasia and a narrow definition would have led to interpretation problems; and (2) medical

120 Eugene Sutorius, "Euthanasia in the Netherlands: The Legal Scene", in *Euthanasia in the Netherlands: A Model for Canada?*, p. 18.

121 Leenen 21:20

122 P. van der Maas, J.J.M. van Delden and L. Pijnenborg, "Euthanasia and Other Medical Decisions Concerning the End of Life." *Health Policy*, vol. 22 (1993)

advances have created broad grey areas between withholding/withdrawal of treatment, pain control and life-terminating acts at the request of the patient.

A decision to withhold or withdraw a life-prolonging treatment can be as decisive in its consequences as administering drugs with the purpose of hastening the end of life. Moreover, the medical situation around the end of life will require the simultaneous consideration as to withdrawing or withholding treatment, intensifying the alleviation of pain and/or symptoms, with shortening of life as a side-effect and the administration of drugs with the purpose of hastening the end of life.<sup>123</sup>

In order to enhance the accuracy of the study, a three-part design was used. The first part of the study consisted of an extensive interview (average duration 2 1/2 hours)<sup>124</sup> with a sample of physicians: approximately 152 general practitioners, 203 specialists, and 50 nursing home physicians. The interviews were carried out by experienced physicians and other academics, all of whom received extensive training. Phase two, performed by the Dutch Bureau of Statistics, was a review of all death certificates over a five month period. The third part of the study required the physicians interviewed in phase one to complete a questionnaire for each patient in their care who died within approximately six months following the initial interview. Eighty percent of physicians interviewed in phase one participated in this follow-up study.

Because of the complexity of the study, and the need to weight the results between the different studies and the different types of physicians involved, the results can be difficult to interpret. For example, the questionnaire in part one (the physician interview) was different than the questionnaire in parts two and three.

### **3.2 Scope of the van der Maas Study**

The general subject of the study was “medical decisions concerning the end of life” (MDEL). This term as used in the van der Maas study:

covers all decisions made by physicians concerning courses of action aimed at hastening the end of life of the patient or courses of action for which the physician takes into account the probability that the end of life of the patient is hastened. The (course of) action(s) concerned are: withdrawing or withholding treatment (including tube feeding) and administering, supplying or prescribing of drugs. Refusal of a request for euthanasia or assisted suicide and decisions not to resuscitate are also included in this investigation of medical decisions concerning the end of life.<sup>125</sup>

Not included were the complications of medical interventions or errors where there was no intent to end the life of the patient, and decisions concerning the care of the patient, allowing the patient to die at home, or other usual medical interventions where a possible hastening of death was not involved.

MDELs were classified on the basis of four questions: what does the physician do? what is the physician's intent in doing this? did the patient request this intervention? was the patient able to decide upon this intervention?

There are three ways in which a physician can intervene: administering drugs that (possibly) hasten the end of life, and either withholding or withdrawing a (possible) life-prolonging treatment. These can occur in combination, as when terminating a life-prolonging treatment leads to administering drugs that may shorten life.<sup>126</sup>

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123 van der Maas, pp. 5-6.

124 *Ibid.* p. 14.

125 *Ibid.* pp. 19-20.



The data that caused the most controversy are found in chapters 6 (life-terminating acts without the patient's explicit request), 7 (alleviation of pain and symptoms) and 8 (non-treatment decisions). In all cases, the physician's intention is crucial, and is dealt with somewhat differently than in Canada:

It can be assumed that termination of life can never be the most important aim in the interaction between physician and patient. If a physician deliberately performs actions that shorten the patient's life it can be argued that, in final analysis, termination of the patient's suffering is intended and that under certain circumstances, also according to the physician's judgement, this suffering cannot be terminated in any way other than by termination of life.<sup>127</sup>

Three categories of intention were recognized for the purposes of the study:

Category I: (acting with) the explicit purpose of hastening the end of life;

Category II: (acting) partly with the purpose of hastening the end of life;

Category III: (acting while) taking into account the probability that the end of life will be hastened.

In Canada, the first category would normally be considered murder. However, during the video-conference, Dr. J.J.M. van Delden, a member of the Rummelink Commission Research Team, described the situation in the Netherlands as follows:

We had one category for research purposes which was phrased in the following manner: "the explicit intent to shorten the patient's life", not "to kill". As a matter of fact, most doctors who answered that they had performed an NTD [non-treatment decision] with the explicit purpose to hasten the end of the patient's life, meant that they did not want to prolong suffering...

... In 6 per cent of the cases of alleviation of pain and symptoms [APS], the intention was described as the explicit purpose to hasten the end of life. In the case of euthanasia, the intention was described by the same wording, as you know. If the context is taken into account, however, one will soon realize that, in the case of euthanasia, the decision was made to hasten the end of life and then the means were sought. In the cases of APS, however, there is ongoing medical treatment which is failing to achieve its palliative goal. The physician sees himself as confronted with the need to use higher, possibly lethal, doses. There may be a point at which the physician realizes that he or she actually hopes that the patient dies. Thus, the physician answers the research question that his purpose, at least partly, was to hasten the end of life.

Those cases prompt us to speak of the boundary area around euthanasia. But are the intentions the same as in the euthanasia cases? I do not think so. In the case of euthanasia, the physician would surely have tried another drug if the first one failed. In the case of APS, that would never have happened.<sup>128</sup>

The third category of intention would presumably correspond to the Canadian concept of potentially life-shortening pain control, which is a generally accepted aspect of palliative care. Between the first category (an explicit intent to shorten life in order to alleviate pain and symptoms) and the third category (potentially life-shortening pain control) lies a grey zone. This second category is described in the van der Maas study:

This distinction of the two major categories still does not solve the difficulty that many physicians cannot always indicate what their intention actually had been in a certain case. Sometimes an intervention is performed to achieve one particular effect (e.g. pain relief) but the side-effect (e.g. death) is not unwelcome. Strictly speaking, this situation should be

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126 *Ibid.* p. 20.

127 *Ibid.* p. 21.

128 van Delden 21:13; see also *Dances with Data* It should also be noted that, because of the low number of physicians involved in the study, the 6 per cent of physicians represents under 20 actual physicians.



categorized as intentional intervention. In order to be considered unintentional, this side-effect should in fact not have been desired. This strict interpretation could not be adhered to when the questionnaire was constructed because there were occasions when, in the opinion of the physician, neither description did justice to his intention. We therefore allowed for the third category (acting) partly with the purpose of hastening the end of life'. This description relates to a situation in which death of the patient was not foremost in the physician's mind but neither was death unwelcome. This type of intention was included specifically in the questionnaire for the alleviation of pain and/or symptoms.<sup>129</sup>

Several other definitional issues of the van der Maas study should be noted. These were the concepts of "terminal phase"<sup>130</sup> or the "concrete expectancy of death"; "medically futile"; and "do not resuscitate decisions". The van der Maas study suggests that there was "great resistance against the use of [terminal phase] as a criterion for the admissibility of euthanasia."<sup>131</sup> This appears to evolve from the Dutch point of view that the essential criterion is relief of intolerable suffering, rather than only intolerable physical pain, as well as the difficulty of defining "terminal".

As for the concept of "medically futile", the van der Maas study concluded that:

This concept plays an important role in the non-treatment discussion, with or without a request of the patient. Jurisprudence has appeared, meanwhile, in which this concept has been used. There is nevertheless no uniform definition. The concept of "futile" depends too much on what is considered to "have a point", i.e. to make sense. This concept was therefore not used in the questionnaires because its interpretation is too variable.<sup>132</sup>

"Do not resuscitate" decisions are defined as situations in which "there is an explicit agreement that:

the patient will not be resuscitated if a (functional) cardiac and/or respiratory arrest occurs. This anticipating decision is called a DNR (do not resuscitate) or NTBR (not to be resuscitated) decision. Such decisions play an important role in clinical practice. In this investigation they are also considered as an MDEL."<sup>133</sup>

### 3.3 Euthanasia and Assisted Suicide

The data resulting from the van der Maas survey with respect to euthanasia or assisted suicide are not particularly controversial. However, the definitions used are not generally familiar to a North American audience and this can cause some ambiguity.<sup>134</sup>

In virtually all cases there was a strong and explicit request (96%), made wholly by a patient (99%) who was totally able to take a decision (98%) and who had a good insight into the disease and prognosis (100%).

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129 van der Maas, p. 21.

130 As will be noted in the main body of the report, the definition of "terminal phase" has caused difficulties in Canada as well

131 van der Maas, p. 23.

132 *Ibid.* p. 24.

133 *Ibid.* pp. 23-4.

134 Since euthanasia requires an explicit request, situations in which a patient is incapable of consenting are never included in Dutch discussions of euthanasia. Euthanasia is an intentional act to terminate life by a person other than the person who dies, upon the request of the person who dies. Assisted suicide is the intentional assistance given to a person to terminate his or her own life upon that person's request. The distinction between euthanasia and assisted suicide therefore depends upon whether the drug is administered by another or taken by the patient. However, because the incidence of assisted suicide is so low, it was treated together with euthanasia for most of the study.

The request was usually repeated (94%).<sup>135</sup> Medical colleagues were consulted in 84% of the cases, and relatives informed in 94% of the cases.<sup>136</sup>

Of approximately 130,000 deaths in Holland in 1990, the study estimated that 1.8 percent (approximately 2,300) resulted from euthanasia, and .3 percent (approximately 400) resulted from assisted suicide. There were an estimated 25,000 requests per year for euthanasia or assisted suicide "in due course" (general requests if the suffering became unbearable), and an estimated 9,000 requests for euthanasia "in the foreseeable future" (specific requests based on an existing situation). The study did not deal further with the 25,000 general requests.

The study estimated that 4,000 out of 9,000 specific requests a year were seriously considered by the physician but refused because the situation did not justify it (e.g. there were still alternative possibilities for alleviating pain, the suffering was not unbearable, the request was not well considered or the patient did not properly understand his/her disease, the patient withdrew the request after discussion, or the physician had specific objection in the particular case or objected in principle to euthanasia and/or assisted suicide).

The remaining 2,000 or so requests (other than the 4,000 which were refused and 2,700 which were carried out) involved situations where the patient died before the request could be carried out, where the physician did not consider the request sufficiently explicit to accept or deny, and where there was neither a refusal nor an action by the physician because the patient changed his/her mind or did not persist.

The reasons most generally cited for requesting euthanasia were loss of dignity (57%), pain (46%), not dying in a dignified way (46%), dependence (33%) and tiredness with life (23%). The vast majority of requests were from cancer patients (83%), although cancer accounts for under 30% of deaths in Holland.<sup>137</sup> The fact that unworthy dying was the most commonly cited reason for requesting euthanasia may account for the reluctance among Dutch physicians to limit requests for euthanasia to patients suffering from an irreversible and painful physical ailment.

At the time the decision to perform euthanasia or assisted suicide was made, most of the patients were receiving only palliative treatment for the relief of suffering (77%). Others were receiving no treatment (14%), treatment that was life prolonging but not curative (10%) or curative treatment (2%).<sup>138</sup>

These data can be interpreted in different ways. Dr. Karl Gunning, felt that these figures were questionable because of the different definition of euthanasia used by the Dutch. He explained his concern as follows:

You may have heard that the committee [Rommelink] concluded that of the 130,000 people who die annually in Holland, only 2,300 were killed by euthanasia. However, if you read the report well, you will come to the conclusion that their definition of euthanasia is different from what is used in the rest of the world.

The definition of euthanasia is "to cause consciously the death of a patient". The Rommelink committee said that euthanasia is "to end consciously the life of a patient at his own request". Of course, if you add the words "at his own request", the committee is completely right when it says that there were only 2,300 cases of euthanasia. However, if you read the report further, you will come to the conclusion that a lethal drug was given

135 van der Maas, p. 45, Table 5.8, p. 50, Table 5.15.

136 In another four percent of the cases, the reason for not informing relatives was either because the patient did not wish it or there were no relatives to inform. van der Maas, p.50, Table 5.15.

137 *Ibid.* pp. 44-45, Tables 5.5 and 5.8.

138 *Ibid.* p. 45, Table 5.6. More than one answer could be given, so figures do not total 100%.

to almost 4,000 people. This is so, because assisted suicide and the giving of a lethal drug when not requested were not regarded as euthanasia. Thus, you could calculate that there were something in the order of 16,000 cases in which either the treatment was slow, started, or stopped, or an overdose of drugs was given with the intention to shorten the patient's life.

*Gunning 17:90*

### 3.4 Life-Terminating Acts Without the Patient's Explicit Request (LAWER)

The single most controversial aspect of the van der Maas study is the finding that almost one percent of deaths during the time under consideration (.8%, or approximately 1,000) might be from life-terminating acts without explicit and persistent requests. Here again, one must consider the rigorous guidelines used in the study. The introduction to the series of questions asked of physicians included the following:

There are situations in which it is decided to perform a life-terminating act without the patient's request to do so. This can occur if the patient has made only vague remarks but not an explicit request. Other situations in which this might happen are, e.g., those in which the patient is no longer able to make such a request, or if the condition of the patient is evidently intolerable...

In this introduction and the instruction to the interviewer it was not specified that cases involved must be cases in which the explicit purpose was hastening the end of life.<sup>139</sup>

During the video- conference, the experts from the Netherlands addressed the issue of 1,000 deaths without requests for euthanasia:

**Mr. Leenen:** I have been involved with advice on euthanasia for 20 years. I was surprised to hear about the 1,000 cases. We know that at the end of life some patients experience such severe suffering that something needs to be done. This occurs in the United States, as well as in your country. At this point in time, the patient is no longer able to express his or her will. In my opinion, this happens in but a few cases. They are the exceptions which we discussed [earlier].

When we look at the 1,000 cases and read the article published in *The Lancet*, we see that in 60 per cent of cases the will of the patient was known. Out of the 1,000 some 600 had expressed their will. However, their will was not in accordance with legal norms. It was not persistent, reiterated, et cetera. Because of the fact that they did not comply with the rules, the researchers decided to put them in the category of "non-requests".

This leaves us with 400 cases to consider. Of this number, we know that some cases are acceptable because, at the end of life, painkilling was no longer possible; they were suffering. I would say that there were also cases which were not according to the rules. Some say that this need not happen any longer. It has been suggested that we should develop a new policy by which to ask people earlier what they want, thereby not waiting until they are incompetent or comatose.

To be fair, I am not happy about the 300 or so cases that we know of where termination of life was applied. By the way, in our terminology, termination was applied: it is not euthanasia. There are two things to consider here: first, we know about it; we know what is happening concerning these cases, but many countries do not know what is happening.

Second, there is now the possibility for us to develop a new policy towards these patients. I am against termination of life without request. It should occur only in exceptional cases.

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139 *Ibid.* p.57.



I am in favour of euthanasia, but only on request. We are not happy about having 300 or 400 termination-of-life cases where the rules were not applied. But do not exaggerate. Dr. Gunning says that information is one sided, but this is not true. There are not 10,000 to 20,000 cases. This applies to 300 cases, perhaps a maximum of 400, and I am not happy about these. ...

**Dr. van Delden:** I wish to add something to Professor Leenen's presentation.

I agree that we are not trying to defend all these cases. They were a surprise to us and some of them should not have occurred. But I am hesitant to refer to the number 300 or 400 because you must be aware that this is based on 47 cases we found in the study. It is difficult to take these 47 into higher numbers.

**Dr. van der Wal:** We should not argue too much about the exact numbers, but I have done some research in this field, too. Our numbers for life-terminating acts without request in the nursing home situation were lower than those found by the van der Maas group.

21:26-27

Of the cases at issue, the patient was totally unable to assess the situation or make an adequate decision in three-quarters of the cases involved, and not totally able to do so in another 14% of the cases. In over a quarter of the cases the patient had made a non-explicit request (such as "Doctor, please help, I no longer want to suffer").<sup>140</sup>

In over nine out of ten cases (92%), there were no treatment alternatives. In the remaining cases, the alternatives were not used because the patient had indicated that he or she no longer wanted treatment, because it would only prolong suffering, or because the gain to be expected was no longer in proportion to the treatment. Over three-quarters (76%) of the patients already required morphine or morphine-like drugs for the relief of pain, and in almost one-half of the patients (45%) these drugs were not effective against pain or other symptoms. "On the one hand, this attests to the seriousness of suffering in the situations described and on the other hand it exemplifies the difficulty of distinguishing these cases from those described in the next chapter under "alleviation of pain and symptoms."<sup>141</sup>

Almost two-thirds of these cases involved either morphine only or morphine in combination with other drugs, while thirty percent used other sedatives with or without muscle relaxants. This reverses the statistics for euthanasia and assisted suicide, where other sedatives were used over two-thirds of the time and morphine only one-quarter, and is similar to the drug profile used in the alleviation of pain and symptoms.<sup>142</sup> In almost nine out of ten cases, life was shortened by less than a week (67%) or a month (21%).

The most important considerations to the physician when performing a life-terminating act were as follows (more than one answer could be given):

No chance of improvement	60%
All medical therapy had become futile	39%
No needless prolongation	33%
Relatives could no longer cope	32%
Low quality of life	31%
Pain/suffering of patient	30%
Wish by patient	7%
A therapy had been withdrawn but patient did not die	3%

140 van der Maas, pp. 61-62, Table 6.4.

141 *Ibid.* p. 62, Table 6.5.

142 *Ibid.* pp. 47, 66; Tables 5.10, 6.9.



Economic considerations(e.g. scarcity of beds	1%
Other	1% <sup>143</sup>

In over 70% of the cases, life was shortened by a maximum of one week.<sup>144</sup> Of the 97 cases studied, only two involved situations where there were no discussions with a patient who was totally able to make a decision. Both cases dated from the early 1980s, when the legal situation was less clear. One involved a patient with a lung tumour with metastases who suffered much pain:

The physician had known this patient for 15 years. The most important consideration for the physician to administer an overdose of morphine was to no longer prolong suffering. ...In a non-verbal understanding with the patient's wife the decision to increase greatly the dose of morphine was taken.

The second comparable case also concerned a patient with cancer in whom alleviation of pain and/or symptoms was intensified to the extent that the patient died within one day. "The patient's suffering was intolerable for everyone. Patient and relatives could no longer stand it."<sup>145</sup>

Had there been explicit requests by the patients, these would presumably have been cases of euthanasia. On the other hand, had the suffering been tolerable, the intent would have to been to control the pain rather than cause death.<sup>146</sup>

Nonetheless, the statistic continues to disturb the Dutch themselves. "In all cases it was not a criminal attitude of the doctor but paternalism - the doctor thinking it was best for the patient. But, that said, it still shouldn't have happened," said Dr. Gerrit van der Wal, a medical inspector for North Holland who conducted an independent study that confirmed the Rummelink data.<sup>147</sup>

### 3.5 Alleviation of Pain and Symptoms

The first question that was asked physicians in this section of the van der Maas interviews was "Did you ever face a situation in which you had to give such high doses of morphine or morphine-like drugs that it almost certainly would shorten the life of the patient?"<sup>148</sup> More than 80% of physicians, regardless of speciality, had done so. In approximately two-thirds (65%) of the cases, the life-shortening effect was simply "accepted". In 30 percent of the cases the life-shortening effect was part of the intent, although not the primary intent. In 6 percent, it was the explicit purpose. For the Dutch, this raises interesting issues of intent. How do these 6 percent of cases differ from euthanasia, assuming that there was an explicit request by the patient?

If the context is taken into account, however, one will soon realize that in the cases of euthanasia the decision was made to hasten the end of life and then a means was sought. In those cases of APS, however, there is an ongoing medical treatment which fails to achieve its palliative goal. The physician then sees himself confronted with the need to use higher, possibly lethal dosages. Then there may be a point at which the physician realizes that he or she actually hopes that the patient dies. So the physician answers us that his purpose (at least partly) was to hasten the end of life. Those cases prompted us to speak of a boundary area around euthanasia. But are the

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143 *Ibid.* p. 64, Table 6.7.

144 *Ibid.* p. 65, Table 6.10

145 *Ibid.* pp. 68-69.

146 Within the Canadian palliative care system, it seems possible that these two cases would have resulted in total sedation.

147 Mullens, "The Dutch way of death" in *Euthanasia, op. cit.*, p. 19.

148 van der Maas, p. 71.

intentions one and the same as in the euthanasia case? Not necessarily. In the euthanasia case the physician would surely try another drug if the first failed to bring about death, whereas in the second [case of relieving pain] this would never happen. One misses this relevant point if one uses too narrow a concept of intentions by leaving out context.<sup>149</sup>

### 3.6 Non-treatment decisions

In a later article dealing with claimed misrepresentation of their data, the van der Maas study team made the following comment:

Concerning withholding or withdrawing of treatment it can be commented that the decision was to not prolong life by a certain period of time rather than to shorten life in the same period. The correct terminology depends on whether or not the results of usual medical treatment are considered part of human life expectancy.<sup>150</sup>

This is also true of situations in which a non-treatment decision is made without the explicit request of the patient, in cases where the patient is no longer competent.

On the one hand, therapies are involved which will probably meet with little or no success. Such treatment can be withdrawn or withheld for this reason. On the other hand, there are cases in which therapies can have a considerable (more than a month) life-prolonging effect but in which prolongation of life is undesirable or pointless and treatment is withheld or withdrawn for this reason.<sup>151</sup>

The non-treatment decisions are, perhaps unsurprisingly, the most difficult to quantify. The van der Maas team estimated that approximately 70% of physicians had at some point received and acted upon a request to withdraw or withhold treatment; almost half (46%) had received and acted upon such a request knowing that it was, at least in part, with the intention of shortening life. Approximately two-thirds of the situations (64%) involved cancer patients. Contrary to the situation when euthanasia or assisted suicide is requested, there is less of a role for the doctor to play because the patient has the clear right to refuse treatment.<sup>152</sup>

Decisions to withhold or withdraw treatment are normally made as the issue arises. "Do not resuscitate orders", on the other hand, are anticipatory decisions, always involving inaction rather than action.

### 3.7 Reporting MDELs

The van der Maas study was completed before the policy of non-prosecution for euthanasia when specific procedures are followed had been finalized, and physicians were presumably more concerned about prosecution in borderline cases. Nonetheless, three quarters of the general practitioners and about two-thirds of the specialists had reported their last experience with euthanasia or assisted suicide as a "natural death", and this seems troublingly high. The main reasons were as follows:

the "fuss" of a legal investigation	55%
the desire to safeguard relatives from a judicial inquiry	52%
fear of prosecution	25%
bad experiences in the past with stating non-natural death	12% <sup>153</sup>

149 Johannes J.M. van Delden, Loes Pijnenborg and Paul J. van der Maas, "Dances with Data," *Hiertus*, Vol. 1 (1993), pp.26-27.

150 *Dances with Data*, p. 24.

151 van der Maas, p. 85.

152 *Ibid.* pp. 79-84, Table 8.1.

In the category of life-terminating acts without the patient's explicit request, the death certificate almost invariably stated that the patient died a natural death. Of the 97 cases studied, only in one did a general practitioner report a non-natural death and the public prosecutor decided not to prosecute. The reasons given were as follows:

the "fuss" of a judicial investigation	47%
the view that the death was in fact natural	43%
the desire to safeguard relatives from a judicial inquiry	28% <sup>154</sup>

In considering the reluctance of Dutch physicians to report non-natural deaths in an atmosphere of some legal ambiguity, it is worth noting a parallel situation in Canada shortly after the 1969 abortion legislation was passed. For the first several years, it was not clear whether or not abortions could be legally approved when it was the "mental" rather than the "physical" health of the woman that was at issue. Under these circumstances, the Badgley Report (Report of the Committee on the Operation of the Abortion Law, 1977) found that the reporting of abortions had some major anomalies:

The way the existing classification system is used requires extensive review, in particular, dealing with the codification of abortions listed as not specified as induced or spontaneous. By definition, these abortions are neither spontaneous miscarriages nor induced terminations of pregnancy. But between 1970 and 1973 there were nine abortions in this catch-all category for every ten reported therapeutic abortions.<sup>155</sup>

Recent developments in the Netherlands suggest that reporting has greatly improved. In 1984, only 19 cases of euthanasia were reported to the public prosecutor. In 1990, the number was 454, and by 1992 it had leapt to 1,322.<sup>156</sup> In 1993 1,415 cases were reported.<sup>157</sup> During the video-conference, the "spectacular" increase was attributed to the "reticent prosecution policy of the public prosecutor and the notification procedure which has been functioning since the end of 1990". Until 1994, the number of cases prosecuted had also declined. Dr. van der Wal explained that this was partially due to the evolving jurisprudence, which lessened the need for test cases.

However, the fact that prosecution proceedings are almost never instituted anymore is due mainly to the fact that physicians who, having been informed about the prudent care requirements that should be taken into consideration, only report those cases for which they are almost certain they will not be prosecuted.

However, the conclusion that all unreported cases do not meet the standards is not justified. Our research indicates that most of these cases meet the substantive material requirements.

*van der Wal 21:10*

Another development has been the suggestion that the Ministry of Justice is toughening up its prosecution policy. In 1993, the number of official inquiries into euthanasia cases jumped to 14, although they recently always been no more than four per year, resulting in a corresponding increase in the prosecutions in 1994. The Ministry of Justice apparently argues that most of these investigations are a backlog of cases held up by the parliamentary debate over the new law. However, during the parliamentary debate, the Minister of Justice argued that euthanasia was justified only in terminal cases and most of the 1993 investigations involved situations in which the patient was not terminally ill. All major legal commentators criticized the Minister's viewpoint and the Supreme Court, in Chabot has clarified that assisted suicide is acceptable, under very strict

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<sup>153</sup> *Ibid.* pp. 47-48.

<sup>154</sup> *Ibid.* p. 64.

<sup>155</sup> *Report of the Committee on the Operation of the Abortion Law* (The Badgley Committee), Ottawa, 1977, p.25.

<sup>156</sup> van der Wal and Dillman (1994), p. 1348.

<sup>157</sup> Legemaate (1994), p. 6.



conditions, in cases of severe and intractable mental suffering where the patient is not terminally ill.<sup>158</sup> It remains possible that the perception that the prosecution policy could change, depending upon the views of the current Minister of Justice, may have caused some unease among physicians.

### 3.8 The van der Wal studies

The van der Wal studies were not publicly funded, and resulted in a thesis and several papers. In part they involved an extensive survey, by written questionnaire, of more than 1,000 general practitioners. Of these, approximately 700 were nursing home physicians which represents almost the total complement of nursing home physicians in the country. Whereas the van der Maas study dealt with all medical decisions concerning the end of life, the van der Wal study dealt only with euthanasia, assisted suicide and, to some extent, life terminating acts without express consent. The van der Maas study involved specialists as well as general practitioners and nursing home physicians. The van der Maas study was more broadly based, but the van der Wal study went into more depth about such issues as performance, medical technology and notification issues. The results of the two studies were by and large consistent.<sup>159</sup>

### 3.9 The Controversy Over Figures

As the above discussion indicates, there has been considerable controversy over whether the Rummelink findings underestimated the number of cases of euthanasia actually taking place in the Netherlands. During the video conference, the Dutch panel explained where the confusion seems to take place:

Usually [critics of the Dutch model] add up the following types and numbers of MDEL, which stands for medical decisions concerning the end of life: euthanasia; assisted suicide; LAWER cases, or life-terminating acts without explicit request by the patient; APS cases, or decisions to alleviate pain and symptoms; and NTD cases, or non-treatment decisions which were taken at least partly for the purpose of hastening the end of the patient's life. All these are lumped together and are taken as proof that more euthanasia than was reported occurred in the Netherlands.

*van Delden 21:12*

Clearly, from the Canadian point-of-view, alleviation of pain and symptoms and non-treatment decisions are not euthanasia. Again, however, the Dutch approach to the concept of "intention" appears to generate some of the confusion. In the Netherlands, it is common to refer to the primary or secondary intention of the physician as "to hasten the end of the patient's life". In Canada, although similar situations take place as in the Netherlands, the intent is rarely referred to as hastening the end of the patient's life although that is doubtless the effect. Dutch physicians apparently assume that if you know that the effect of certain actions is to shorten the patient's life, then you should describe that as at least partially your intent. However, in the view from the Netherlands, intentions do not govern the moral evaluation.

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158 Legemaate (1994) p. 10.

159 van der Wal 21:7



Intentions cannot carry the full weight of a moral evaluation for several reasons. First, intentions are primarily private matters. Ultimately, only the agent decides what his intentions are. Different agents may describe the same action in the same situations as being performed with different intentions. The changes between descriptions might be intrapersonal in the sense that what seems to be done at one time for one purpose might easily be viewed differently at a later stage.

What then can be considered to be the definite description of the intention? For example, no physician, in my opinion, performs euthanasia with the sole intent to kill his patient. His intention can always be described as trying to relieve the suffering of his or her patient. That, by the way, is exactly what infuriates Dutch physicians when they are treated as criminals or murderers after having performed euthanasia.

It is our opinion that moral evaluations should take into account all of the following factors: the type of physician; the intent; consultation with the patient; consultation with others; the competence of the patient; reasons for the decision; and, the extent of life-shortening as a result of the decision.

*van Delden 21:12*

The controversy as to the number of cases of euthanasia that occur in the Netherlands can to some extent be attributed to definitional problems. There are, however, other misunderstandings that can only be attributed to a misinterpretation of Dutch material. For example, the Committee was told by witnesses that 59 per cent of patients undergoing euthanasia died on the same day that they requested euthanasia, and 11 per cent died in the same hour. The author of the paper cited as authority for this disturbing accusation was Dr. van der Wal, who explained what his paper had actually said:

Yes, [the patients] did die on the same day that they requested euthanasia for the last time. Do you understand the difference? The patients had discussed the subject and had explicitly requested euthanasia many times before, but the day on which they died was the last time that they requested it.

The next sentence says that in 11 per cent of cases, patients died in the same hour that the first request was made. It was not the first request; it was the last request. If you would like to verify this, you should read my paper in *Family Practice* which has been mentioned today.

*van der Wal 21:62*

## **Summary**

In a complex situation, dealing with a complex subject, only one thing seems clear. The approach of the Netherlands to the difficult subject of euthanasia and assisted suicide is unique. It grows out of Dutch culture, Dutch law and the Dutch health care structure. As Dr. Robert Dillman, the Secretary of Medical Affairs for the Royal Dutch Medical Association, has succinctly stated: “[The Dutch approach] should not be taken as a model. Euthanasia is not an export product.”<sup>160</sup>

What we observe in the Netherlands is a modern experiment in dealing with medical decisions surrounding the end of life. The outcome remains to be seen. It appears that the majority of the Dutch people support physician-assisted death at the end of life, where there is an informed and persistent request by a patient undergoing intolerable suffering and with no prospect of improvement. There is, however, considerable concern about some recent developments. Situations in which a physician has assisted the suicide of a patient with psychological or emotional suffering, but no physical disease, have aroused unease. Ending the lives

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160 Mullens, “The Dutch way of Death”, in *Euthanasia*, p. 16.

of profoundly handicapped newborns, whose physical suffering cannot be alleviated, is as difficult and controversial a decision in the Netherlands as elsewhere.

Although to date the Dutch experiment has been driven by the courts and the medical profession, it is by no means impossible that the legislature will take action in the future. This would put Dutch policy on a different, and firmer, footing and clarify the public interests involved.

Outside of the Netherlands, it seems that the Dutch experiment with end of life medical decisions has, to some extent, taken on the aura of a morality play. The figures become larger than life, and the tone becomes black and white with none of the shadings of grey that occur in everyday life. In fact, what is happening in the Netherlands is an attempt by one small country, with a history of openness and of respect for individuality, but no monopoly on the truth, to come to grips with one of the most fundamental and difficult issues of our time.

If Canadians can learn one thing from the Dutch experiment, it is that nothing about the issue of euthanasia and assisted suicide will ever be simple or ever be unemotional. It is not a problem that can be solved by attacking the actions of others, but by building, with care and tolerance, the approach best suited to our own culture, our own laws, and our own health care structure.

## Appendix 1

### Data from the van der Maas Study

	As %	Total No.
Total deaths in Netherlands in 1990		128,786
Category:		
1. Euthanasia and related MDEL	2.9	3,735
1a. Euthanasia	1.8	2,318
1b. Assisted suicide	0.3	386
1c. Life-terminating acts without explicit and persistent request	0.8	1,030
2. APS (Alleviation of pain and symptoms)	17.5	22,538
3. NTD (Non-treatment decisions)	17.5	22,538
Total MDEL (Medical Decisions concerning the End of Life)	38.0	48,939

\*Source: van der Maas, P.J. et al., "Euthanasia and Other Medical Decisions concerning the End of Life," 338, The Lancet 669, at p. 670.

### Euthanasia and Assisted Suicide

Number of requests for "in due course"		25,000
Number of requests for "in the foreseeable future"	approx.	8,900
Number of such requests seriously considered but refused	approx.	4,000
Euthanasia related MDEL	approx.	3,735
Remaining requests: data inaccuracies, patient died, not considered explicit, or not pursued by patient	approx.	2,000

Source: van der Maas, P.J. et al., Euthanasia and other Medical Decisions Concerning the End of Life. Published in English as a special issue of Health Policy, Vol. 22 (1993), at p. 40-41, 52.

## Alleviation of Pain and Symptoms

	%	Number
Intent of physician when morphine shortened life		
Taking into account the probability that life would be shortened	65.0	14,625
Partly with the purpose of shortening life	30.0	6,750
With the explicit purpose of shortening life	6.0	1,350
Decision discussed with patient	39.0	8,775
Decision not discussed, patient totally able to take a decision	27.0	6,075
Decision not discussed, patient not (totally) able to take a decision	34.0	7,650

Source: van der Maas (1993), Table 7.2, p. 73.

## Non-Treatment

	%	Number
Non-treatment without consent, of which		25,000
taking into account the probability that a life would be shortened	65.0	16,250
partly with the purpose to shorten life	19.0	4,750
with the explicit purpose to shorten life	16.0	4,000
Non-treatment without consent, of which		
patient able to assess situation and make a decision		
totally able	22.0	5,500
not totally able	21.0	5,250
unable	58.0	14,500
After consultation with		
colleagues	54.0	13,500
nursing staff	56.0	14,000
relatives	60.0	15,000
pastor or spiritual advisor	3.0	750
no consultation	8.0	2,000

Source: van der Maas (1993), p. 85, 89, 90.

## Appendix P

# Assisted Suicide and Euthanasia in Foreign Jurisdictions

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*This paper provides an overview of the applicable laws relating to euthanasia and assisted suicide, as well as any initiatives to amend such laws, whether successful or not, in the following foreign jurisdictions: United Kingdom, United States, France, Australia, Germany, Sweden and Switzerland. The method of selection of the various countries was based primarily on the quantity of available information. It should be noted that this is not, in any way, an extensive comparative legal analysis of the listed countries. The information herewith only provides a basic framework within which to begin to examine and compare the differential treatment, in law, of acts of euthanasia and assisted suicide in other jurisdictions. A more detailed analysis would require an in-depth study, not only of the various laws with respect to issues involving death and dying, but their enforcement, the legal practice and the cultural climate in which these have developed.*

### UNITED KINGDOM

#### Assisted suicide

In the United Kingdom, assisting in the suicide of another is dealt with under the *Suicide Act 1961*.<sup>161</sup> Section 2 of this Act provides:

**2. Criminal liability for complicity in another's suicide**

*(1) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.*

*(2) If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence.*

#### Euthanasia

All acts of killing are considered murder, whether or not the victim consented to or requested death. This is evident from the evidence of the Home Office to the House of Lords Select Committee on Medical Ethics:<sup>162</sup>

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<sup>161</sup> 9 & 10 Eliz 2, c.60. The provisions of the *Suicide Act 1961* that have been cited in this paper only apply to England and Wales, pursuant to subsection 3(3) of that Act.

<sup>162</sup> *Report of the Select Committee on Medical Ethics*, Session 1993-94, HL Paper 21-IIp. 15.



At present, the criminal law prescribes that the unlawful deliberate killing of another person is murder in all but a few circumstances. Most existing defences to murder rely on an absence of intention or an absence of responsibility for the act committed, with the result that the necessary *mens rea* does not exist. What is critical in this context is that the law allows no defence to murder on the basis of motive. A person who kills, with that as their clear intention and in their right mind, is guilty of murder even though they may have been motivated by a desire to end another's suffering or to give effect to their victim's clearly and honestly held wishes. The Scots law of murder is in certain respects different from that of England and Wales. However, it also recognises that, where the necessary intent to kill can be proved, there will be no defence to murder based on the consent of the victim or the motive of the accused.

In the United Kingdom, murder is an offence at common law that carries a mandatory life sentence. The English courts have defined that act of murder as follows:<sup>163</sup>

Subject to three exceptions, the crime of murder is committed where a person of sound mind and discretion unlawfully kills any reasonable creature in being and under the Queen's peace with intent to kill or cause grievous bodily harm the death following within a year and a day.

The three exceptions referred to in the above extract would reduce murder to manslaughter and these exceptions have been codified in the *Homicide Act 1957*.<sup>164</sup> They are the following: provocation, diminished responsibility and suicide pacts. The exceptions that may be relevant to cases of euthanasia are diminished responsibility and suicide pacts and these are set out below:

2.(1) *Where a person kills or is a party to the killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing.*

(2) *On a charge of murder, it shall be for the defence to prove that the person charged is by virtue of this section not liable to be convicted of murder.*

(3) *A person who but for this section would be liable, whether as principal or as accessory, to be convicted of murder shall be liable instead to be convicted of manslaughter.*<sup>165</sup>

4.(1) *It shall be manslaughter, and shall not be murder, for a person acting in pursuance of a suicide pact between him and another to kill the other or be a party to the other killing himself or being killed by a third person.*

(2) *Where it is shown that a person charged with the murder of another killed the other or was a party to his killing himself or being killed, it shall be for the defence to prove that the person charged was acting in pursuance of a suicide pact between him and the other.*

(3) *For the purposes of this section "suicide pact" means a common agreement between two or more persons having for its object the death of all of them, whether or not each is to take his own life, but nothing done by a person who enters into a suicide pact shall be*

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163 *Archbold Pleading, Evidence and Practice in Criminal Cases* London: Sweet & Maxwell, 1992, p. 2042.

164 5 & 6 Eliz 2, c.11.

165 *Homicide Act 1957*, 5 & 6 Eliz 2, c.11.

*treated as done by him in pursuance of the pact unless it is done while he has the settled intention of dying in pursuance of the pact.*<sup>166</sup>

It should be noted that the elements of manslaughter are the same as those of murder with the exception of the requirement for murder that there should be an intent to kill or cause grievous bodily harm. Further, with respect to diminished responsibility and suicide pacts, the onus is cast upon the accused to prove the facts reducing the offence to manslaughter on a balance of probabilities.<sup>167</sup>

## Case law

The case of Dr. Nigel Cox<sup>168</sup> and his conviction in 1992 for attempted murder after he administered a lethal dose to a suffering patient prompted great controversy in the United Kingdom.

The facts involved a consultant rheumatologist at the Royal Hampshire County Hospital Winchester. He had injected his patient, Mrs. Lillian Boyes, who he had known for thirteen years, with a large dose of potassium chloride. She subsequently died. Mrs. Boyes was in her final stages and she was in extreme pain from rheumatoid arthritis. Any treatments that had been attempted had failed to alleviate her physical pain. On more than one occasion, she had expressed the wish that the medical staff should end her life.

The charge, in this case, was attempted murder rather than murder because the prosecution could not exclude the possibility that Mrs. Boyes had died of natural causes between the actual injection and her death. Dr. Cox was found guilty as charged because the jury found as fact that he had injected his patient with potassium chloride for the primary purpose of killing her. The fact that one is prompted by compassion for the victim's suffering is irrelevant to the charge of attempted murder.<sup>169</sup> Accordingly, the judge, in this case, Judge Ognall, cautioned the jury that motive could afford the doctor no defence under the relevant criminal laws. Dr. Cox received a one year suspended sentence and was admonished by the General Medical Council.<sup>170</sup>

More recently, a case was reported in a London newspaper, the *Observer*, in which the Crown Prosecution Service [hereafter CPS] had decided not to charge a man with killing his terminally ill wife, despite having sufficient evidence to do so. The CPS decided as it did because it was felt that it would be in the public interest. The news clipping suggests that this was the first identified case in which the CPS has declined to prosecute in a killing because it believed that the victim was killed on compassionate grounds. The woman, in this case, was in the terminal stages of cancer. A post-mortem report indicated that she had not died from the cancer, but rather from an overdose of morphine. She had been receiving morphine through a motorised syringe driver which evenly administered regular doses throughout a 24-hour period. The CPS believed that on November 19, 1993, at 10 p.m. she had received a fatal dose of the drug.<sup>171</sup>

166 *Ibid.*

167 *Archbold*, p. 2042.

168 The Cox decision was one of the cases that prompted the study on medical ethics in the House of Lords: see *Report of the Select Committee on Medical Ethics*, Session 1993-94, HL 21-lp. 8-9.

169 In the case at bar, the defence had asserted that Dr. Cox was prompted by compassion for Mrs. Boyes' suffering and this was not disputed by the prosecution.

170 For a discussion of the facts in *R v. Cox* (Crown Court at Winchester) [unpublished], see Great Britain, House of Commons Library, Research paper by Keith Cuninghame (June 21, 1993) at 2. For an edited version of Ognall J.'s charge to the jury, see *R v. Cox* (1992) 12 B.M.L.R. 38.

171 Dean Nelson and Helen Murphie, "UK: No Charges over "Mercy Killing"", the *Observer*, 4 December 1994.

## Proposed Amendment Initiatives

In February 1994, a Select Committee of the House of Lords [hereafter the Committee] reported on “the ethical, legal and clinical implications of a person’s right to withhold consent to life-prolonging treatment, and the position of persons who are no longer able to give or withhold consent; and to consider whether and in what circumstances actions that have as their intention or a likely consequence the shortening of another person’s life may be justified on the grounds that they accord with that person’s wishes or with that person’s best interests; and in all the foregoing considerations to pay regard to the likely effects of changes in law or medical practice on society as a whole”.<sup>172</sup> For a complete list of the recommendations of the House of Lords, see Appendix N to this Report.

In its Report, the Committee recommended that the present laws not be amended to permit voluntary euthanasia. Its members write: “We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have serious and widespread repercussions.”<sup>173</sup>

One of the reasons the Committee reached its conclusion regarding voluntary euthanasia is that its members were of the view that it would not be possible to set secure limits on voluntary euthanasia. If voluntary euthanasia were legalised, they argued, it would not be possible to frame adequate safeguards against non-voluntary euthanasia. In addition, the Committee felt that to create an exception to the general prohibition of intentional killing would inevitably lead to its further erosion. The Committee also expressed its concern for the vulnerable, namely, the elderly, the lonely, the sick and the distressed; these individuals, it held, would feel pressure from the rest of society to select the option of death if it were made available to them.<sup>174</sup>

Moreover, the Committee members recommended that a new offence of “mercy killing” not be created to encompass cases of deliberate killing to relieve suffering (“deliberate killing with a merciful motive”). They write: “To distinguish between murder and “mercy killing” would be to cross the line which prohibits any intentional killing, a line which we think it essential to preserve”.<sup>175</sup> The Committee was of the opinion that “mercy killing” could not adequately be defined since it would involve delineating precisely what constitutes a compassionate motive.<sup>176</sup>

The Committee did, however, acknowledge the perceived injustice of the mandatory life sentence for murder. It, therefore, recommended, as did a previous Select Committee<sup>177</sup>, that the mandatory life sentence be abolished. In its report, the Committee concluded as follows:<sup>178</sup>

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172 *Report of the Select Committee on Medical Ethics*, Session 1993-94, HL 21-I p. 7.

173 *Ibid.* p. 48.

174 *Ibid.*, p. 49.

175 *Ibid.*, p. 53.

176 *Ibid.*, p. 53.

177 *Murder and Life Imprisonment*, Report of the Select Committee, Session 1988-89, HL Paper 78-I cited in *Report of the Select Committee on Medical Ethics*, *op. cit.*, p. 53.

178 *Report of the Select Committee on Medical Ethics*, *op. cit.*, p. 54.



This [abolishing the mandatory life sentence] would enable the judicial process to take proper account of the circumstances of a case and the motives of the accused. It would avoid the law being brought into disrepute either by the mandatory imposition of a life sentence in respect of an act which was widely thought to be compassionate and (by some) arguably justifiable, or by the inappropriate substitution of lesser charges where it was expected that a jury would not convict for murder because of the mandatory life sentence. It would also give scope for an effective life sentence to be imposed where the circumstances made it appropriate.

## UNITED STATES

### Assisted Suicide

Approximately thirty of the fifty states have statutes which specifically prohibit aiding suicide.<sup>179</sup> Those states which do not proscribe assisted suicide by unique statutes treat such conduct as murder or manslaughter under general criminal law statutes.<sup>180</sup>

### Euthanasia

All forms of euthanasia are classified as murder in every state, even when performed at the victim's request or with the victim's consent.<sup>181</sup> For example, the California Penal Code provides that "Murder is the unlawful killing of a human being with malice aforethought".<sup>182</sup> It is first degree murder if the killing is "wilful, deliberate, and premeditated".<sup>183</sup> The consent of the victim in no way vitiates the crime, and the fact that the victim was terminally ill or that the actor was motivated to act out of compassion will not excuse the crime nor will it be considered as a mitigating factor.<sup>184</sup>

### Case law

In various states, the prohibitions against assisted suicide have been challenged in the courts under the Fourteenth Amendment to the United States Constitution. In *Quill et al. v. Koppell*,<sup>185</sup> the U.S. District Court in New York City held that physician assisted death is not constitutionally protected and that the New York prohibition against assisted suicide does not violate the equal protection clause. Judge Griesa writes at 84:

179 Alaska Stat. & 11.41.120 (1989); Ariz. Rev. Stat. Ann. & 13-1103 (A)(3)(1989); Ark. Stat. Ann. & 5-10-104 (a)(2)(1987); Cal. Penal Code & 401 (West 1988); Colo. Rev. Stat. & 18-3-104 (1988); Conn. Gen. Stat. & 53a-56 (1985); Del. Code Ann. tit. 11, & 645 (Supp. 1990); Fla. Stat. Ann. & 782.08 (West 1976); Ill. Ann. Stat. ch.38, 12-31 (Smith-Hurd Supp. 1992); Ind. Code Ann. & 35-42-1-2.5 (Burns 1993); Kan. Stat. Ann. & 21-3406 (1988); Me. Rev. Stat. Ann. tit. 17-A, & 204 (1983); Mich. Pub. Act 270 of 1992, 1992 Mich. Legis. Serv. P.A. 270 (H.B. 4501) (West); Minn. Stat. Ann. & 609.215 (West 1987); Minn. Stat. Ann. & 147.091 (W), 151.06 (a)(7)(xii)(West Supp. 1993); Miss. Code Ann. & 97-3-49 (1972); Mont. Code Ann. & 45-5-105 (1989); Neb. Rev. Stat. & 28-307 (1989); N.H. Rev. Stat. Ann. & 630:4 (1986); N.J. Stat. Ann. & 2C: 116 (West 1982); N.M. Stat. Ann. & 30-2-4 (1978); N.Y. Penal Law & 120.30, 125.15(3) (McKinney 1987); Okla. Stat. Ann. tit. 21, & 813-818 (West 1983); Or. Rev. Stat. & 163.125(1)(b) (1990); Pa. Stat. Ann. tit. 18, & 2505 (Purdon 1983); S.C. Code Ann. & 16-1-10 (Law Co-op 1976); S.D. Codified Laws Ann. & 22-16-37 & 38 (1988); Tex. Penal Code Ann. & 22.08 (West 1989); Wash. Rev. code & 9A.36.060 (West 1988); Wis. Stat. Ann. & 940.12 (West 1982), cited in Kathryn L. Tucker, "Physician Aid in Dying: A Constitutional Right", at p.1 (February 1995) [unpublished]. For a detailed discussion of the state treatment of suicide assistance, see Catherine D. Shaffer, "Criminal Liability for Assisting Suicide" (1986) 86 *Columbia Law Review* 348.

180 See Shaffer, *Criminal Liability for Assisting Suicide*, p. 350.

181 Dana Elizabeth Hirsch, "Euthanasia: Is It Murder or Mercy Killing? A Comparison of the Criminal Laws in the United States, the Netherlands and Switzerland" (1990) 12 *Loy. L.A. Int'l & Comp. L.J.* 1990 821 p. 839.

182 Cal. Penal Code & 187(a) (West Supp. 1988).

183 Cal. Penal Code & 189 (West Supp. 1988).

184 *Euthanasia: Is It Murder or Mercy Killing?*, op. cit., 833; Mustafa D. Sayid, "Euthanasia: A Comparison of the Criminal Laws of Germany Switzerland and the United States" (1983) 6 *Boston College International & Comparative Law Review* p. 547.

185 Civil No. 94-5321 (TPG) slip op. (SDNY Dec. 15, 1994).



Self-destruction is surely not conduct to be encouraged or taken lightly. The fact that penal sanctions will prove ineffective to deter the suicide itself does not mean that the criminal law is equally powerless to influence the behaviour of those who would aid or induce another to take his own life. Moreover, in principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request of the suicide victim...For these reasons, the court holds that the type of physician assisted suicide at issue in this case does not involve a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment.

And later at 85:

It is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device. The State has obvious legitimate interests in preserving life, and in protecting vulnerable persons. The State has the further right to determine how these crucial interests are to be treated when the issue is posed as to whether a physician can assist a patient in committing suicide. Clearly in the present public debate there are sincere and conscientious advocates for and against the concept of physician assisted suicide. Under the United States Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the State. For these reasons the court holds that the plaintiffs have not shown a violation of the Equal Protection Clause of the Fourteenth Amendment.

The United States District Court of Washington took the opposite view with respect to the constitutionality of the Washington assisted suicide prohibition. In *Compassion in Dying, et al. v. State of Washington et al.*,<sup>186</sup> the plaintiffs were a coalition of three terminally ill patients, five physicians and Compassion in Dying, a right to die organization. They sought a declaratory judgment striking down the State of Washington's criminal prohibition against assisted suicide<sup>187</sup> as unconstitutional and injunctive relief barring the defendants, the State of Washington and the Washington Attorney General, from enforcing the statute. Both the plaintiffs and defendants moved for summary judgment.

The United States District Court of Washington granted summary judgment to the plaintiffs holding that competent, terminally ill patients have a constitutionally protected right to choose to hasten death with physician assistance. The Court further held that Washington's assisted suicide statute is unconstitutional under both the Liberty and Equal Protection Clauses of the 14th Amendment. Judge Rothstein held at 1461 to 1462:

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186 850 F. Supp. 1454 (W.D. Wash. 1994).

187 RCW 9A.36.060. Subsection (1) of this statute provides that "Any person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide". Promoting a suicide attempt is a class C felony punishable by imprisonment for a maximum of five years and a fine of up to ten thousand dollars: see RCW 9A.36.060(2) and 9A.20.020(1)(c).

The liberty interest protected by the Fourteenth Amendment is the freedom to make choices according to one's individual conscience about those matters which are essential to personal autonomy and basic human dignity. There is no more profoundly personal decision, nor one which is closer to the heart of personal liberty, than the choice which a terminally ill person makes to end his or her suffering and hasten an inevitable death...The court concludes that a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted suicide.

And later at 1467:

This court is not persuaded that the distinction between "natural" and "artificial" death justifies disparate treatment of these similarly situated groups. The distinction between the terminally ill patient who requests that her physician remove the life support systems necessary to maintain her life, and the terminally ill patient whose condition does not require life support systems but who seeks physician-administered aid to end her life, is not a narrowly-drawn classification tailored to serve a compelling state interest. Both patients may be terminally ill, suffering pain and loss of dignity and subjected to a more extended dying process without some medical intervention, be it removal of life support systems or the prescription of medication to be self-administered.

The Court concluded, at 1467, as follows:

The court declares RCW 9A.36.060 [*Washington State's assisted suicide statute*] unconstitutional because it places an undue burden on the exercise of a protected Fourteenth Amendment liberty interest by terminally ill, mentally competent adults acting knowingly and voluntarily, without undue influence from third parties, who wish to commit physician-assisted suicide. The court further declares RCW 9A.36.060 unconstitutional because it violates the right to equal protection under the Fourteenth Amendment by prohibiting physician-assisted suicide while permitting the refusal or withdrawal of life support systems for terminally ill individuals.

It is important to note that the above-noted decisions are lower court decisions. *Compassion in Dying v. State of Washington* was, in fact, appealed to the Ninth Circuit Court of Appeals on December 7, 1994.<sup>188</sup> A decision is forthcoming in the spring of 1995. It is expected that *Quill v. Koppell* will be appealed as well.

In addition to the foregoing cases, which were both decided at the federal level, the Michigan State courts have confronted similar issues in various challenges to Michigan laws prohibiting assisted suicide. In December 1994, the highest Michigan State court held that the federal constitution provides no right to physician-assisted death.<sup>189</sup>

### Proposed Amendment Initiatives

A number of unsuccessful formal proposals that sought to legalize euthanasia and/or assisted suicide were introduced in various states. They are as follows:<sup>190</sup>

188 Appeal docketed, No. 94-35534 (9th Cir. 1994).

189 *People v. Kevorkian*, Nos. 99591 and 99674, consolidated with *Hobbins et al. v. Michigan*, No. 99752, slip op. pp.22-44 (Mich. Dec. 13, 1994).

190 Cheryl K. Smith and Michele A. Tropkowski, eds., *Aid-In-Dying Legislative Proposals 1990-1993* (Oregon: The Hemlock Society U.S.A., 1993; Russel Ogden, *Safeguarding Euthanasia: Legislative Proposals in Canada and in the United States* (for the 46th Annual

*Washington Initiative 119 (1991)*: The Initiative for Death With Dignity would have permitted voluntary euthanasia for competent, terminally ill adults with fewer than six months to live. A number of specific safeguards were outlined in the legislation. This Act was defeated in a state referendum by a vote of 54 to 46 per cent.

*California Proposition 161 (1992)*: The *Death With Dignity Act* would have legalized both euthanasia and physician-assisted suicide by recognizing the right of mentally competent, terminally ill adults, with a life expectancy of less than six months, to give written authorization for a physician to terminate life in a “painless, human and dignified manner”. This legislation was defeated in a state referendum by a vote of 54 to 46 per cent.

*Iowa Senate File 2066: The Assistance in Dying Act* would have provided a means for conscious, mentally competent adults who are terminally ill and expected to die within six months to receive voluntary euthanasia through a written declaration.

*Maine Legislative Document No.2257 (1992)*: This Act dealing with “medically assisted death” would have permitted voluntary physician assisted euthanasia for competent, terminally ill adults who are expected to die “within a relatively short time”.

*Michigan House Bill 5415: The Death With Dignity Act 1992* would have permitted competent adults to authorize or reject aid in dying. This Act would have required counselling for the patient, a 60 day waiting period, video-taping of the implementation of the directive and reporting of aid-in-dying procedures.

*New Hampshire House Bill 395: The Death With Dignity Act* would have allowed mentally competent, terminally ill adults to request assistance in suicide, but not active euthanasia. The Act would have required that the attending physician consult with a medical ethics committee regarding the patient’s prognosis, competence, and the voluntariness of the request.

*Oregon Senate Bill 1141*: This Bill would have permitted voluntary euthanasia for competent, terminally ill adults with fewer than six months to live. It also contained an option for patients in a permanent coma or vegetative state. It would have allowed patients to make an advance declaration requesting euthanasia in the event of permanent coma or a persistent vegetative state.

*Texas Senate Bill 1301 (1993)*: This Bill would have allowed competent, terminally ill persons, including minors, to petition a probate court for a medically assisted death. The assisted death would have to be witnessed by at least two adults.

*New York Article 49 (1994)*: This Article would have provided for competent, terminally ill adults with fewer than six months to live to request aid in dying. It outlined a number of safeguards and required reporting of all aid in dying procedures.

To date, the only proposal to permit a form of aid in dying in the United States that has been successful is Measure 16, filed in the State of Oregon by ERGO, *Euthanasia, Research & Guidance Organization*. This measure is a state-wide citizens’ initiative that allows qualified patients to request prescriptions for medication to end their lives provided that certain conditions are met.<sup>191</sup> This Measure, entitled the *Oregon Death With Dignity Act*, was formally passed on November 8, 1994 by a vote of 51 to 49 per cent. However, the initiative was challenged on constitutional grounds prior to its coming into force by two physicians, four terminally ill

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Conference of the American Society of Criminology, 1994) [unpublished] p. 10-12.

191 The state-wide initiative process is a constitutionally valid method of passing legislation in the State of Oregon. One of its advantages is that it provides an alternative to proceeding by way of the legislature and enables the population to more actively participate in the legislative process.



patients, a residential care facility and individual operators of residential care facilities.<sup>192</sup> The plaintiffs brought a motion for a preliminary injunction postponing the implementation of the legislation until the constitutional issues were resolved. Judge Hogan of the United States District Court for the District of Oregon granted the injunction as of December 27, 1994.

It should also be noted that several states have appointed “Blue Ribbon” task forces to analyze and make recommendations to the state legislatures. The Task Forces have split on the issue. For example, the task force established in New York recommended against legislative reform, while that in Michigan favoured legislative reform.<sup>193</sup> For a complete list of the recommendations of the New York State Task Force, see Appendix N to this Report.

## FRANCE

### Assisted Suicide

There is no specific provision prohibiting assisted suicide in the French *Penal Code*. An assisted suicide may, however, be treated as a failure to assist a person in danger, pursuant to section 63 of the *Code*. This section provides:

Without prejudice to the possible application of the harsher punishments provided for in this Code or other specific legislation, every one who, without risk to himself or another, by taking immediate action, could prevent an act that is a crime or that is an offence against the physical integrity of a person and wilfully refrains from doing so, is liable to three months to five years’ imprisonment and a fine of 360 F to 20,000 F or to either of these punishments.

A person who wilfully refrains from assisting a person in danger where, without risk to himself or another, he could provide assistance, either by his own action or by summoning help, is liable to the same punishments provided for in the preceding paragraph.

In 1988 in order to counter a self-help suicide book, the government enacted two new sections to the *Code* prohibiting the provocation of suicide. Provoking a suicide is, therefore, distinguished from assisted suicide in France.

The National Assembly preferred “provoking suicide” to the concept of “inciting and assisting” suicide used in the private bill passed by the Haute Assemblée. The deputies did not wish to use the private bill to deal with the sensitive issue of euthanasia.<sup>194</sup>

The sections are now found in the revised *Penal Code* and they provide:

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192 *Lee et al. v. State of Oregon, et al.*, No. 94-6467-H0 (D.Or.).

193 Tucker, “Physician Aid in Dying: A Constitutional Right”, p. 13.

194 Report on behalf of the commission on constitutional laws, legislation, universal suffrage, regulations and general administration concerning the private bill amended by the National Assembly prohibiting the provocation to suicide, No. 172, first ordinary session of 1987-1988, Senate, annex to the proceedings of the December 16, 1987 sitting, p. 11.



*223-13 Provoking the suicide of another is punishable by three years' imprisonment and 300 000 F in fines where the provocation has been followed by suicide or attempted suicide.*

*The punishment increases to five years' imprisonment and 500 000 F in fines where the victim of the offence set out in the preceding paragraph is a minor of fifteen years.*

*223-14 Propaganda or publicity in any form on behalf of products, objects or methods recommended as means of suicide is punishable by three years' imprisonment and 300.00 F in fines.*

*223-15 Where the offenses provided for in articles 223-13 and 223-14 are committed by means of the print or the audiovisual media, the specific legal provisions governing these matters apply with respect to the determination of the persons responsible.*

The above noted sections do not apply to assisted suicide but are limited to cases of provoking another's suicide.

## **Euthanasia**

Acts of euthanasia are considered homicide in the French *Penal Code*.

Sections 295 and 296 of the *Code* deal with homicide. They read as follows:

*295. Voluntary homicide is murder.*

*296. A murder committed with premeditation or by ambush is assassination.*

In addition, sections 221-5 and 221-6 of the revised *Penal Code* provide:

*221-5 The murder of another through the use or administration of substances capable of causing death is poisoning [...] and is punishable by 30 years' imprisonment.*

*221-6 Causing the death of another through clumsiness, carelessness, lack of attention, negligence or failure to observe a statutory or regulatory duty of safety or caution is involuntary homicide, punishable by three years' imprisonment and 300.000 F in fines.*

It should be noted that the motive of the accused or the request of the victim will not provide an excuse under the law and will not mitigate the crime.

However, as a result of the revision of the *Penal Code* in 1986, the doctrine of “état de nécessité” was codified in the new article 122-2, which provides:

*122-2 A person who acted under the influence of force or duress, which the person was unable to resist, shall not be punished.*

## **Case law**

The professional magistrature applies in a fairly strict manner the provisions of the *Penal Code* to cases of euthanasia. However, the “Cours d'Assises”, generally competent to hear these cases, are very lenient and acquit accused persons almost systematically. At a minimum, the extenuating circumstances will be considered.<sup>195</sup> The jury, in these cases, is only required to give a “yes” or “no” answer with respect to the

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195 Euthanasia, European affairs services, comparative legislative section, Senate, Paris, January 1991, p. 18.

question of culpability and is not required to provide reasons for its decision. As such it is difficult to ascertain the applicable legal principles regarding euthanasia cases.

With respect to section 63 of the *Penal Code* dealing with the failure to assist a person in danger, the case law suggests that individuals can be found guilty of such an offence if they have failed to prevent a suicide or failed to intervene in time to prevent the completion of the act.<sup>196</sup>

The highly publicized case of *M. Le Bonniec* dealt with section 63 paragraph 2. Le Bonniec was one of the authors of the self-help book on suicide. A person who had read the book had written to the author on two occasions indicating his suicidal intentions and asking for advice on methods of committing suicide. The author gave him information on the dose needed to commit suicide. The person went on to commit suicide. The author was charged with failing to assist a person in danger. He was found guilty at his original trial.

On appeal, the Court of Appeal confirmed the judgment of the lower court based on the following reasons:

First, because the author, from reading the letters (of his correspondent), “was unable to doubt the determination (of his correspondent) to implement his plans to kill himself” and because of “the imminent danger” to which the latter was exposed. Second, “because, on the evidence, immediate intervention was required to prevent continuing and imminent mortal danger to Michel Bonnal whose psychological distress and vulnerability were known to Yves Le Bonniec”. Next, “because the author could have used his influence or alerted a prevention association”. Finally, and above all, “because by providing to the desperate person the information he had requested, he made it possible for the person to carry out his suicidal intentions.” The Court, noting the failure to assist a person in danger, substantially increased the punishments and sentenced Le Bonniec to six months’ imprisonment, with a stay, 10,000 F in fines and civil damages.<sup>197</sup>

The “Chambre criminelle” affirmed this decision.<sup>198</sup>

## Proposed Amendment Initiatives

An unsuccessful bill was introduced in the Senate in May 1989 which would render legal a declaration of volition to die in dignity<sup>199</sup>. The proposition provides that:

Any person having reached the age of majority who is suffering from a disease that the person considers disabling, incurable, irreversible, pathological or intolerable may make a declaration:

requesting that all possible means be used to alleviate his suffering, even if the only means that are still effective could shorten his life...

The declaration of volition would have to be in writing and signed by the declarant. The declaration would need to be renewed every five years and could be revoked at any time. The declarant could name an agent to ensure that his wishes were carried out. The bill states that it would not be a crime or a tort to help a person

<sup>196</sup> Euthanasia, European affairs services, comparative legislative section, Senate, Paris, January 1991, p. 18.

<sup>197</sup> Jacques Borricand, La répression de la provocation au suicide: de la jurisprudence à la loi [criminalizing provocation to suicide: from judicial decisions to legislation], *La Semaine Juridique*, Ed. G. no. 46, #3359.

<sup>198</sup> Cass. crim. 26 avril 1988: Bull. crim. n. 178.

<sup>199</sup> Private bill no. 312, rectified, legalizing a declaration of a wish to die in dignity and amending article 63 of the Penal Code. Paris, Senate, 18 May 1989, introduced by Mr. Boeuf and Mr. Laucournet.

die if the person is acting pursuant to the patient's request or pursuant to the request of his agent acting under the declaration. The bill would also modify section 63 of the *Penal Code* in order that doctors or other health care providers can allow the person to benefit from euthanasia without criminal consequences.

Another bill<sup>200</sup> was introduced in December 1989 in the National Assembly identical to that presented in the Senate. This proposition expired with the change of the National Assembly in 1993.

Yet another bill entitled, "Proposition de résolution sur l'assistance aux mourants," was presented to the European Parliament in April 1991 and would have permitted euthanasia in certain circumstances in hospitals and palliative care centres. The *Comité National Consultatif d'Ethique* and the *Conseil National de l'ordre des médecins* in France disapproved of this resolution. It was not adopted by the European Parliament.

## AUSTRALIA

While Australia is a federal state, the administration of the criminal justice system is primarily a matter of individual state and territory responsibility.<sup>201</sup> There are three sources of criminal law in Australia: the criminal codes of Queensland, Western Australia, the Northern Territory, and Tasmania; the common law which applies with little legislative interference in Victoria and South Australia; and the *Crimes Act* 1900 which applies in New South Wales and the Australian Capital Territory.<sup>202</sup>

### Assisted Suicide

Assisted suicide is an offence in all Australian jurisdictions. In the Australian Capital Territory, New South Wales, South Australia and Victoria, it is an offence for a person to incite, counsel, aid or abet another to commit suicide or attempt to commit suicide.<sup>203</sup> Under the Codes in the Northern Territory, Queensland and Western Australia, it is an offence to "procure" or "counsel" another to kill himself or "aid" another killing himself.<sup>204</sup> In Tasmania, it is an offence to "instigate or aid another to kill himself".<sup>205</sup> The penalties provided for assisted suicide vary from jurisdiction to jurisdiction. For example, in the Australian Capital Territory, the penalty for such conduct is imprisonment for 10 years.<sup>206</sup> By contrast, in New South Wales, a distinction for punishment is drawn between aiding, abetting and inciting, or counselling suicide. The former carries a penalty of up to 10 years while the latter is punishable by up to 5 years.<sup>207</sup> In South Australia, the penalty is more severe if the suicide was successful.<sup>208</sup>

The circumstances surrounding the offence, the condition of the person wishing to commit suicide, a request for assistance in committing suicide, and the motivating factors for the offence are all irrelevant in establishing the elements of the offence of assisted suicide.<sup>209</sup>

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200 Private bill legalizing a declaration of a desire to die in dignity, no. 999, National Assembly, introduced by Mr. Bernard Charles.

201 Margaret Otlowski, "Mercy Killing Cases in the Australian Criminal Justice System" (1993) 17 *Criminal Law Journal* 10 p. 11.

202 Ian Temby, "Euthanasia - Is it Murder" (1988) 21:1 *Australian Journal of Forensic Sciences* 2 p. 3.

203 *Crimes (Amendment) Ordinance (No.2)* 1990 (A.C.T.), s.17(1),(2); *Crimes Act* 1900 (N.S.W.), s.31c(1),(2), as amended by the *Crimes (Mental Disorder) Amendment Act* 1983 (N.S.W.); *Criminal Law Consolidation Act* 1935 (S.A.), s.13 (a) (5),(6),(7), as amended by the *Criminal Law Consolidation Act Amendment Act* 1983 (S.A.); and *Crimes Act* 1958 (Vic.), s.6B(2).

204 *Criminal Code* 1983 (N.T.), s.168; *Criminal Code* 1899 (Qld), s.311; *Criminal Code* 1913 (W.A.), s.288.

205 *Criminal Code* 1924 (Tas.), s.163.

206 *Crimes (Amendment) Ordinance (No.2)* 1990 (A.C.T.), s.17(1),(2).

207 *Crimes Act* 1900 (N.S.W.), s.31c(1),(2), as amended by the *Crimes (Mental Disorder) Amendment Act* 1983 (N.S.W.)

208 *Criminal Law Consolidation Act* 1935 (S.A.), s.13(a)(5),(6)(7), as amended by the *Criminal Law Consolidation Act Amendment Act* 1983 (S.A.).

209 Margaret Otlowski, "Mercy Killing Cases" p. 12.



Some states have specific statutory provisions dealing with suicide pacts. In Victoria, for example, where a person is acting pursuant to such a pact and either kills the other or is party to the other being killed by a third person, he or she is guilty of manslaughter.<sup>210</sup> By contrast, in New South Wales, the survivor of a suicide pact is not guilty of murder or manslaughter, but may be found guilty of the offence of aiding, abetting, counselling or inciting suicide.<sup>211</sup>

## Euthanasia

The law with respect to euthanasia is fairly uniform throughout Australia. Under existing criminal law principles in both criminal code<sup>212</sup> and common law jurisdictions,<sup>213</sup> any act deliberately undertaken to bring about the death of a person is treated as murder.<sup>214</sup>

It should be noted that, for the purpose of establishing criminal liability, it is irrelevant that the person killed was terminally or incurably ill, that a request to die was made on the part of the deceased<sup>215</sup> or that the offender acted out of compassion for the deceased. As one author writes:

The fact that the administering physician might be acting out of compassion and from the highest motives does not change the characterization of the offence as murder. The requisite *mens rea* or mental element of the crime — that of an intention to kill — would be present, as would the *actus reus*, the performance of the criminal act. Motive is not taken into account, nor is it relevant that the patient requested his own death, or that death from natural cause may have been imminent.<sup>216</sup>

In the past, life imprisonment was the mandatory sentence for murder in all Australian jurisdictions. This was replaced by a maximum sentence of life imprisonment in some states. The sentence for murder is now discretionary in the Australian Capital Territory, New South Wales and Victoria. Life imprisonment is still mandatory for murder in the following jurisdictions: Northern Territory, Queensland, South Australia, Tasmania and Western Australia.<sup>217</sup>

## Case law

In Australia, prosecutions in cases of assisted suicide and euthanasia are rare.<sup>218</sup> An example of a discontinued prosecution is a case in 1983 that occurred in the Australian Capital Territory. The facts involved a woman who had killed her terminally ill sister, the latter of whom had previously expressed a wish to die. The Commonwealth Attorney General decided not to prosecute despite the fact that a *prima facie* case of

210 *Crimes Act*, 1958, section 6B(1),(3),(4).

211 *Crimes Act*, 1900, s.31B cited in Sharma, "Euthanasia in Australia" p. 138.

212 Tasmania, Queensland, Western Australia and the Northern Territory.

213 Victoria and South Australia. In New South Wales, the criminal law is primarily contained in the *Crimes Act* 1900 (N.S.W.). This Act also applies in the Australian Capital Territory by virtue of s.6(1) of the *Seat of Government Acceptance Act* 1909.

214 Otlowski, "Mercy Killing Cases" p. 12 and Temby, "Euthanasia" p. 3.

215 It should be noted that in all jurisdictions, the consent of the victim is irrelevant with respect to homicide. For example, section 53(a) of the Tasmanian *Criminal Code* provides: No person has a right to consent to the infliction (a) of death upon himself;... and any consent given in contravention hereof shall have no effect as regards criminal responsibility. All the other criminal code states have similar provisions. In the common law states, the case law provides that a person cannot consent to his or her own death. See Sharma in "Euthanasia in Australia" p. 133.

216 K.M. Sharma, "Euthanasia in Australia" (1986) 2 *Journal of Contemporary Health Law and Policy* 133. Also see Otlowski, "Mercy Killing Cases" p. 12.

217 Otlowski, "Mercy Killing Cases" p. 18.

218 Otlowski, "Mercy Killing Cases" p. 13 and Temby, "Euthanasia" p. 6; Sharma, "Euthanasia in Australia" p. 142.



murder was found to have been established. The reason given for this decision was that the evidence was largely circumstantial and a jury would be unlikely to convict.<sup>219</sup>

One example, however, of a prosecution and conviction is the 1983 *R. v. Larkin* case. A nurse had administered a fatal dose of insulin to her partner, a manic depressive who had, on a number of occasions, threatened to commit suicide. The deceased had taken an overdose of tablets while the accused was at work. When she returned home, the deceased once again expressed his wish to die and attempted to inject himself with a fatal dose of insulin. The accused responded to his plea by administering the fatal injection. The Victorian Supreme Court placed the nurse on a three-year good behaviour bond after she pleaded guilty to a charge of aiding and abetting suicide.<sup>220</sup>

The *Barnes* decision, an unreported case of the Supreme Court in New South Wales, involved a nurse's assistant who was charged with attempted murder after allegedly administering an unauthorised dose of pethidine to an elderly patient. He then proceeded to administer an overdose to himself in an attempt to take his own life. The patient survived the overdose but died some time later from natural causes. The accused admitted to having administered the drug in order to kill the patient but claimed that she had been in severe pain and that he acted out of merciful motives. He pleaded not guilty to the charge of attempted murder. At trial, he denied having administered the overdose and said he could not recall what had happened that night. Evidence was put forward that he had been receiving psychiatric treatment. The jury returned a verdict of not guilty.<sup>221</sup>

### Proposed Amendment Initiatives

A number of jurisdictions in Australia have undertaken initiatives for reform with respect to the current laws on euthanasia and/or assisted suicide. The most significant of these initiatives have occurred in the Northern Territory, South Australia, and the Australian Capital Territory where bills have been introduced that would legalize some form of aid in dying.

On February 21, 1995, a private members' bill entitled the *Rights of the Terminally Ill Act 1995*, was introduced by Chief Minister of the Northern Territory, Marshall Perron. The Bill was passed on May 25, 1995 by the 25 member Northern Territory Assembly. The Act gives terminally ill persons the right to request assistance from a medically qualified person to voluntarily terminate their lives. Terminal illness is defined as one which "in reasonable medical judgment will, in the normal course, without the application of extraordinary measures of treatment unacceptable to the patient, result in the death of the patient". Assistance may be given to a patient by a medical practitioner only if a number of conditions are met. They include the following:

The patient must be at least 18 years of age;

The medical practitioner must be satisfied that the patient is suffering from a terminal illness, that there is no medical measure acceptable to the patient that can reasonably be

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219 Due to a suppression order made by the court, the name of the defendant may not be published. For a description of the case, see: Otłowski, "Mercy Killing Cases" p. 15-16 and Sharma, "Euthanasia in Australia" p. 141.

220 Sharma, "Euthanasia in Australia" p. 141 and Otłowski, "Mercy Killing Cases" p. 25.

221 For a more detailed discussion of this case, see Otłowski, "Mercy Killing Cases" p. 20.

undertaken in the hope of effecting a cure, and any available treatment is confined to relief of pain, suffering and/or distress;

The patient must have undergone examination by a second medical practitioner who has confirmed the first practitioner's diagnosis and prognosis;

The illness must be causing the patient severe pain, suffering, and/or distress;

The medical practitioner must have informed the patient of the nature of the illness, its likely course, and the medical treatment available, including palliative care, counselling, psychiatric support, and extraordinary measures;

The patient must be of sound mind as attested to by a medical practitioner;

The patient must make a request in writing and sign it. Two medical practitioners must witness the patient's signature. If the patient is unable physically to sign the form, any person 18 or over (other than the medical practitioners) may, at the patient's request and in his or her presence, as well as in the presence of both witnesses, sign the request on the patient's behalf; and

The medical practitioner must himself or herself provide the assistance and/or remain present while the assistance is given and until the death of the patient.

The *Voluntary Euthanasia Act* 1995 was recently introduced by M.P. John Quirke in the South Australian Parliament. This Act allows assistance in dying for patients who are terminally ill and who have made a request. Any person over 18 years of age who is terminally ill and diagnosed as likely to die within 12 months may make a request for voluntary euthanasia or assisted suicide. The conditions to making such a request include the following:

The terminally ill person must be of sound mind and this condition must be attested to by the witnesses to the request;

The person must be competent to make the decision and must in fact make the decision. A third party has no authority to do so.

The diagnosis of the terminal illness and the prognosis of the case must be confirmed by two medical practitioners: one involved in the case management and the other having confirmed the diagnosis and prognosis, having examined the patient thoroughly, and not having been involved in the day to day management of the particular case;

The request must be made in writing and signed by the terminally ill person. It must be witnessed by a medical practitioner and one other adult witness. An oral request may be made if the person is unable to write. In this latter case, the request may be written by the witnesses and, if practicable, a videotape recording of the making of the request by the terminally ill person must be made; and

The medical practitioner must fully inform the patient of the diagnosis and prognosis of the forms of treatment available including their risks, side affects and likely outcome and the proposed euthanasia procedure, the risks associated with the procedure and feasible alternatives.

In the Australian Capital Territory, draft legislation dealing with euthanasia is being considered by Parliamentary Counsel and is expected to be tabled in June of this year. Michale Moore will introduce the *Voluntary and Natural Death Bill* 1993 which, if passed, would allow a person of sound mind who has attained the age of 18 years and suffering from a terminal illness to request that extraordinary measures not be applied or that a drug be administered for the purpose of inducing death. Section 3 of the Bill defines terminal illness as:

*Any illness, injury or degeneration of mental or physical faculties such that*

*(a) death would, if extraordinary measures were not undertaken, be imminent; or*

*(b) there is an absence of thought or perception;*

*from which there is no reasonable prospect for a temporary or permanent recovery, even if extraordinary measures were undertaken.*

The *Voluntary and Natural Death Bill* sets out a series of conditions and requirements, similar to those set out in the other bills, that must be met in order to be eligible to make a request to obtain assistance in dying. The following are some examples: the request must be witnessed by 2 persons and these must not be either relatives of the person making the direction or persons entitled to a portion of the estate of the terminally ill person; a medical practitioner must inform the person of the nature of his or her illness, alternative forms of treatment, and the consequences of remaining untreated; and the medical practitioner must not comply with the request unless he or she has consulted a second medical practitioner who has not been a treating physician and who agrees with the granting of the request.

## GERMANY

### Assisted Suicide

There is no specific provision prohibiting assisted suicide in the *German Penal Code*. The active participation of one individual in the suicide or attempted suicide of another is not criminalised and is not punishable, provided that the person who committed suicide was in control of the act of suicide pursuant to the doctrine of the “*Tatherrschaft*” that has been developed by the German courts. This doctrine involves being capable of exercising control over one’s action and also acting freely, responsibly and without coercion.<sup>222</sup> As such, while assisting in the suicide of a disturbed, depressed or demented person or one coerced by external forces, would not be permitted under German law, aiding an informed person who voluntarily chooses death, is permitted.<sup>223</sup>

It is fundamental, in order to be exempt from liability, that the final act that causes death be committed by the person desiring death. The justification for the great emphasis placed on the agent of the act is the need to preserve, as much as possible, the availability of the option of reversing the process at any time by the person wishing to die. This control is germane to the doctrine of the “*Tatherrschaft*”: unless the person who seeks death undertakes the final act that brings about the death, there is a lack of control over one’s actions.<sup>224</sup>

The aiding and abetting provisions do not apply in cases of assisted suicide because these offences involve assisting in the commission of an illegal act. Since suicide is not illegal, assisted suicide cannot be an offence under sections 26 and 27(1).<sup>225</sup> These sections read:

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222 See Stephanie Weinhold, “The Right to Die with Dignity in the Federal Republic of Germany and in Canada” (Unpublished) University of Heidelberg, Faculty of Law, 1994 (original in German) p. 27-28; see also Adolf Schoenke and Horst Schroeder, *Strafgesetzbuch: Kommentar*, 24th ed., (Munich: C.H. Beck 1991) p. 1552; Ulfried Neumann, “Die Strafbarkeit der Suizidbeteiligung als Problem der Eigenverantwortlichkeit” in *Juristische Arbeitsblätter* 1987, 244 p. 245; Johannes Wessels, *Strafrecht - Besonderer Teil - I* 23rd ed., (Heidelberg: C.F. Mueller, 1993) p. 9, 36.

223 Margaret P. Battin “Assisted Suicide: Can We Learn from Germany?” (March-April 1992) *Hastings Centre Report* 44 p. 45.

224 Weinhold, “The Right to Die with Dignity” p. 23, 27-28; Schoenke/Schroeder, “Strafgesetzbuch” p. 1514.

225 Weinhold, “The Right to Die with Dignity” p. 23; Johannes Wessels, *Strafrecht* p. 9.



## 26. Accessory before the fact

*Anyone who intentionally causes another to deliberately commit an illegal act shall be punished as if he/she were a perpetrator.*

## 27. Aiding and abetting

*(1) Anyone who intentionally helps another to deliberately commit an illegal act shall be treated as an abettor.*

It has, however, been argued by many German legal scholars that there is an apparent inconsistency in the fact that assisted suicide is not illegal but that there may be a duty imposed upon specific parties standing in certain professional or personal relationships to other persons (e.g. the doctor/patient relationship) to rescue a suicide in progress, pursuant to sections 13 and 323c of the *Code*.<sup>226</sup> These provisions provide:

### 13. Commission through omission

*(1) Anyone who fails to prevent an outcome which constitutes one of the elements of a criminal offence according to a penal Act shall be punishable under that Act only if he/she is legally responsible for ensuring that the outcome in question does not occur, and if the omission is equivalent to actively committing the criminal offence. [Translation]*

### 323c Failure to provide assistance

*Anyone who fails to provide assistance in the case of an accident or common danger or an emergency, even though such assistance is required and the person in question could reasonably be expected in the circumstances to provide such assistance, especially if he/she can do so without any considerable personal risk and without violating any important obligations, shall be punished by the imposition of a fine or a term of imprisonment up to one year.*

These sections establish a positive duty to intervene in certain circumstances. Their effect is to curtail the physician's role in suicides and insulate the patient from *physician* aid in dying.<sup>227</sup> As one author writes, "[A]lthough the physician is not prohibited from giving a lethal drug to a patient, once that patient has taken the drug and becomes unconscious, the physician incurs a duty to resuscitate him or her".<sup>228</sup>

Indeed, some courts have applied these provisions in combination with section 216 [homicide at the request of the person] in order to erode the immunity from criminal prosecution for assisted suicide.<sup>229</sup>

The *Wittig* decision illustrates this point. In that case, a doctor found one of his patients in a state of unconsciousness after she had attempted to commit suicide. He did not undertake any action in order to revive the patient because he was aware of her clearly expressed intention to commit suicide and he assumed she could not be resuscitated without permanent damage. One author expressed the holding in this decision as follows:

226 Walter Gropp, "Suizideteiligung und Sterbehilfe in der Rechtsprechung" in *Neue Zeitschrift fuer Strafrecht* 1986 p. 97; Ulf Bade, *Der Arzt an den Grenzen von Leben und Recht* (Luebeck: Schmidt-Roemhild, 1988) p. 147. For a detailed discussion of the German courts' application of sections 13, 323c and 216 of the *German Penal Code*, see Weinhold, "The Right to Die" p. 31-34.

227 For a more detailed discussion regarding the role of physicians in Germany and the attempt to exclude the medical establishment from assisted suicides, see Battin, "Assisted Suicide" p. 45-46.

228 See Battin, "Assisted Suicide" p. 45-46; see also the *Wittig* decision, BGH, 3. Strafsenat, July 4, 1984.

229 See Battin, "Assisted Suicide" p. 45-46; see also the *Wittig* decision, BGH [Federal Court of Appeal], 3. Strafsenat., July 4, 1984.



The Court [Federal Court of Appeal] held that there was a special relationship between a physician and her/his patients. Moreover, it is a criminal offence according to [sections] 13 and 323c of the German Penal Code to omit helping when faced with an accident and when capable of providing help. The Court utilized the doctrine of “*Tatherrschaft*” and stated that, upon Dr. Wittig’s arrival, there was a change as to who was in control of the last act before the patient’s death. The Court acquitted Dr. Wittig based on the weak argument that he made a “medical decision of conscience” in not reviving the patient because he believed that she had already suffered severe brain damage when he arrived.<sup>230</sup>

This decision has been criticized:

This interpretation of the “*Tatherrschaft*” doctrine significantly undermines the view that assisted suicide is not a criminal offence. Unless death occurs immediately, the situation arises whereby the person giving assistance has to “save” the person wishing to die as soon as that person has lost consciousness. Walter Groop gives the analogy that a person may give the person wishing to die a rope but s/he has to cut the rope as soon as the person wishing to die has lost the capability to act. In essence, the courts are turning the threat of punishment in [section] 216 into an authorization for forced treatment.

Furthermore, the application of [section] 323c of the *German Penal Code* depends upon there being an “accident”. It is questionable whether every attempted suicide can be viewed as an accident.<sup>231</sup>

## Euthanasia

In Germany, acts of euthanasia could potentially fall under one of three categories: murder, manslaughter or homicide at the request of the person killed. The act of killing is considered murder if it is undertaken without the victim’s consent and where the motives behind the act are “selfish” or “base”. Section 211 of the *German Penal Code* provides:

### 211. Murder

(1) *A murderer shall be punished by being imprisoned for life.*

(2) *A murderer is anybody who, maliciously or cruelly, or using means that endanger the public at large, or in order to permit the commission of or to cover up another crime, kills a human being out of the simple love of killing, or to satisfy a sexual urge, or out of greed, or for some other base motives.*

The provision dealing with manslaughter is applicable in cases where the facts involve the killing of a person without his or her consent but in the absence of a “base motive”.<sup>232</sup> Section 212 provides as follows:

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230 Weinhold, “The right to Die with Dignity” p. 4.

231 Weinhold, “The Right to Die with Dignity” p. 5.

232 Mustafa D. Sayid, “Euthanasia: A Comparison of the Criminal Laws of Germany, Switzerland and the United States” (1983) 6 *Boston College International & Comparative Law Review* 533 p. 550.

## 212. Manslaughter

(1) *Anybody who intentionally kills a human being in a manner not amounting to murder shall be punished for manslaughter by being imprisoned for a term of not less than five years.*

(2) *In especially serious cases, the punishment shall be imprisonment for life.*

Furthermore, section 213 of the *Code* mitigates the penalty for manslaughter in the case of “extenuating circumstances”. It reads:

*213. If the person charged with manslaughter was provoked into a fit of anger, without fault of his own, by a battery or serious insult, committed by the deceased against the defendant or one of his relatives, and the defendant was prompted instantly to commit the deed, or if other extenuating circumstances are present, the punishment shall be imprisonment for a term of not less than six months.*<sup>233</sup>

The motive distinguishes murder from manslaughter. Indeed, the *German Penal Code* considers motive as an important element in determining culpability and is considered in both the grading of the offence and the sentencing of the crime. One author, in referring to the *German Code*, wrote:

Once the judge considers the motive of the actor, the character and personality of the criminal becomes apparent...The personality of the actor encompasses “the character of the actor, his dangerousness or harmlessness, [and] the probability or improbability of his repeating the crime”. Thus, in a prosecution for euthanasia, the judge would direct his attention to the total personality of the actor and not merely to a partial view of the homicide. Under this approach, the judge can better view the entire incident and thus be better prepared to render a fair and equitable sentence.<sup>234</sup>

The more widely applied provision in euthanasia cases is section 216, homicide at the request of the victim. This provision allows the courts a certain amount of discretion in terms of sentencing where an express wish to die is articulated in some way. In other words, a communication must be made, either through words or gestures, that the person desires death.<sup>235</sup> The demand must be “serious” and “earnest”; this means that the person wishing to die must be competent and able to freely make the decision.<sup>236</sup> Section 216 of the *Code* stipulates:

233 Sayid, “Euthanasia: A Comparison of the Criminal Laws” p. 551.

234 Sayid, “Euthanasia: A Comparison of the Criminal Laws” p. 547-548.

235 *Uncle* case, BGH, decision of November 25, 1986 can be located in *Neue Juristische Wochenschrift* 18 p. 1092; see Weinhold, “The Right to Die with Dignity” p. 25.

236 See Eduard Dreher and Herbert Troendle, *Strafgesetzbuch und Nebengesetze* (Munich: C.H. Beck, 1993) p. 1199. Schoenke/Schroeder p. 1501; Weinhold, “The Right to Die with Dignity” p. 25.

*216. Homicide at the request of the person killed*

(1) If a person kills another after having been expressly and earnestly requested to do so by the person killed, the punishment shall be imprisonment for a term of not less than six months but not exceeding five years.

(2) The attempt is punishable.

**Case Law**

Although the issue of whether there is a constitutional right to “active euthanasia” has been raised at the lower court level and has been decided in the negative,<sup>237</sup> to date, the German Constitutional Court has declined to settle the question.

**Proposed Amendment Initiatives**

Several unsuccessful proposals to amend section 216 of the *German Penal Code* have been made by German physicians and criminal law scholars. A 1986 initiative offered the following amendment:<sup>238</sup>

Under the conditions set forth in paragraph 1, the court may waive punishment if the killing has put an end to extreme suffering that could no longer be borne by the person in question and that could not have been eliminated or alleviated in any other way.

A second amendment, proposed in 1989, would have read as follows:<sup>239</sup>

Consent does not eliminate the unlawfulness of the killing unless, due to an incurable illness of the person, a continued life is contrary to the interest of the person, and the act is carried out by a physician.

The German Society for Humane Dying (*Deutsche Gesellschaft fuer Humanes Sterben* (hereafter DGHS)),<sup>240</sup> which advocates the decriminalization of euthanasia, has proposed the following amendment to section 216:

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237 *Daniela* case (VG Karlsruhe [Administrative Court of Karlsruhe], decision of December 12, 1987, can be located in *Neue Juristische Wochenschrift* 1988 p. 1536. For a detailed discussion of the *Daniela* case, see Weinhold, “The Right to Die with Dignity” p. 66-68.

238 This proposal is referred to as *Alternativentwurf eines Gesetzes ueber Sterbehilfe* (Alternative draft of a law on aid-in-dying) and was developed by a working group of professors of criminal law and of medicine. For a discussion of the proposal, see: Astrid Muschke, “Gesetzliche Regelung der Sterbehilfe” (Dissertation in Giessen, Germany, 1988) p. 152-153; Heinz Schoeck, “Menschenwuerdiges Sterben und Strafrecht” in *Zeitschrift fuer Rechtspolitik* 1986 p. 236; and Weinhold, “The Right to Die with Dignity” p. 93-94. For the proposal itself, see Albin Eser and Hans-Georg Koch, *Materialien zur Sterbehilfe: Eine Internationale Dokumentation* (Freiburg im Breisgau: Max-Planck-Institut fuer Auslaendisches und Internationales Strafrecht, 1991) p. 153.

239 Law Library of Congress, *Euthanasia in Foreign Countries*, 1994/5 p. 7.

240 DGHS was founded in 1980 to facilitate suicide for those who are terminally ill. For a detailed discussion of its proposed changes, see Weinhold, “The Right to Die with Dignity” p. 94-96; Muschke p. 161; Jutta Detering “Forum: Paragraph 216 und die aktuelle Diskussion um Sterbehilfe” in *Juristische Schulung* 1983 p. 418. As to the proposal itself, see Albin Eser and Hans-Georg Koch, *Materialien zur Sterbehilfe: Eine Internationale Dokumentation* (Freiburg im Breisgau: Max-Planck-Institut fuer Auslaendisches und Internationales Strafrecht, 1991) p. 154-155.

*Under the terms set forth in section 216, consensual killing is not a criminal offence if:*

- (a) the person killed was undergoing extreme suffering which he/she could no longer endure;*
- (b) that person's wish to die was shown to have been lasting;*
- (c) the person killed was physically unable to kill him/herself; and*
- (d) there was no pressure exerted on any of the participants.*

## SWEDEN

### Assisted Suicide

The *Swedish Criminal Code* does not contain an express provision dealing with assisted suicide.<sup>241</sup> However, an act of assisted suicide could result in a charge under the murder or manslaughter provisions of the *Code*. If the charge is murder or manslaughter in an assisted suicide case, the courts will rarely impose the normal punishments for such offences. The imposition of a more lenient sentence in murder and manslaughter cases is possible under Swedish criminal law because the *Criminal Code* contains various provisions permitting a certain amount of discretion in the sentencing process in specified circumstances.<sup>242</sup> One provision of the *Code* provides that a court may impose a more lenient sentence for a crime if the underlying motive for the commission of the offence involves "profound human compassion".<sup>243</sup> The relevant provisions are found in of Chapter 23 of the *Criminal Code*. They provide:

**Section 1.** *In view of a uniform administration of justice, punishments shall be determined within the framework of a scale relevant to the crime or the culpability of the total criminality.*

*When culpability is appraised, special attention shall be paid to the damage, offensiveness or danger brought about by the act, and to the accused person's perception or expected perception about this, as well as to his intentions or motives.*

[...]

**Section 3.** *When culpability is appraised, the following points - in addition to those that are applicable to certain cases - shall be especially regarded as mitigating circumstances:*

- 1. whether the crime was brought on by someone else's grossly offensive behaviour;*
- 2. whether the accused had, as a result of psychological disturbance or excited state of mind or some other reason, a severely impaired ability to control his actions;*
- 3. whether the conduct of the accused was related to his obviously impaired development or experience or ability to judge; or*
- 4. whether the crime was brought about by powerful compassion for fellowman.*

*Lighter sentences than those prescribed for the crime may be imposed, should the crime's culpability indicate this.*

Therefore, according to subsection 4 of section 3, a court may impose a lighter sentence if the underlying reason for the commission of the offence was compassion for the victim.

<sup>241</sup> *Euthanasia in Foreign Countries*, 1994/95, p. 20.

<sup>242</sup> Chapter 23 of the *Criminal Code* as cited in *Euthanasia in Foreign Countries*, *Ibid.* p. 20.

<sup>243</sup> *Euthanasia in Foreign Countries*, 1994/5, p. 20-21.



## **Euthanasia**

All acts of euthanasia are dealt with under the murder and manslaughter provisions of the *Swedish Criminal Code*. They provide as follows:

*Section 1. A person taking another person's life is sentenced for murder to imprisonment for a term of 10 years or for life.*

*Section 2. If a crime indicated is s. 1 is regarded as less serious considering the circumstances leading to it or otherwise, it is subject to a sentence for manslaughter, with imprisonment for a term not less than six years and not exceeding ten years.*<sup>244</sup>

However, as was already noted above, there are certain provisions in the *Swedish Criminal Code* that permit the courts to sentence an accused to a less severe penalty than what the law normally requires for each crime. These provisions are generally invoked in cases involving acts of euthanasia.<sup>245</sup>

## **Case law**

In a leading Swedish case, a journalist was charged with manslaughter for ending the life of a handicapped person, who was almost completely paralysed, on the latter's request. The accused journalist had complied with the wishes of the disabled person by lethal injection and by administering tablets. It was not possible to determine whether the cause of death was due to the injection or the tablets or a combination of both. The death was caused, however, by the administration of these substances. The medication was provided by a physician who did not actively participate in the final act that brought about the death of the disabled person, beyond providing the necessary dosage of medication.<sup>246</sup> The journalist argued that she had only assisted in a suicide and such action was not punishable. The doctor, who was charged with being an accessory to manslaughter, also argued that he had only assisted in a suicide and, thus, no punishment should be imposed.<sup>247</sup>

The District Court of Stockholm, did not accept the argument that both accused had only assisted in a suicide. While accepting that the journalist had acted with compassion and respect for human dignity in complying with the deceased's request, the Court held that since she had actively participated in terminating a life without having any expertise in the field of medicine, she had nonetheless violated the law. Consequently, she was found guilty of manslaughter. However, in light of the circumstances of the case, and the testimony of several witnesses corroborating the statements made by the accused journalist to the effect that the deceased had no desire to continue living, the Court applied the discretionary sentencing provisions for manslaughter and sentenced the accused to a punishment of eight months' imprisonment.<sup>248</sup> The doctor was found guilty of being an accessory to manslaughter and also received a prison sentence. The Court based its decision on the following reasoning:

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244 *Criminal Code*, Ch.3, ss. 1 & 2 (Sveriges Rikes Lag, 1994 cited in *Euthanasia in Foreign Countries*, 1994/5 p. 20.

245 *Euthanasia in Foreign Countries*, 1994/5, p. 21.

246 *Ibid*, p.20

247 Case No. 139 (1979) *Nytt Juridisk Arkiv* (I: 1979) cited in *Euthanasia in Foreign Countries*, 1994/5, p. 20.

248 *Ibid*, p. 20.

Hedeby [the journalist] placed, with intention to end Handberg's life, a lethal dose of sleeping drugs in his mouth and administered liquid to his mouth so that he could swallow the tablets and injected into the bend of his elbow a lethal dose of insulin. These measures, which caused his death, must be regarded as parts of one act. Through this act, Hedeby deprived Handberg of his life, regardless of that he himself had swallowed the sleeping drug...By assisting in the manner alleged by the prosecutor, Toss [the doctor] became guilty of being accessory to manslaughter. [...] STR [Stockholm District Court] does not think that Toss was in a situation that could justify discharge from liability on grounds of emergency.<sup>249</sup>

Both the prosecution and the accused journalist appealed the decision of the District Court. The Court of Appeal confirmed the finding of the District Court judge that the accused journalist had acted on humanitarian grounds. However, the Court concluded that since she had actively participated in bringing about the death of the deceased, it was in the public interest to demonstrate a clear denunciation of the conduct of the accused by imposing a more severe punishment. As such, the Court increased the prison term from eight months to one year. The Court stated:

On the other hand, it has to be noted that the act indicates a serious deviation from the judicial concepts characterizing the Penal Code's provisions, which are based on respect for human life, even in a case where life's value may seem doubtful to a person seriously ill. To leave such deviations without appreciable sanctions could lead to complicated consequences. Existing principles can not be surrendered and euthanasia accepted without relevant legislation or at least some orienting guidelines with a necessary anchorage in society. Therefore, the Appeal Court finds that in consideration of general obedience to the law, it is essential that Hedeby receive a prison sentence which emphasizes the seriousness attached by the Penal Code to the act. The punishment should be more severe than indicated in STR's judgment.<sup>250</sup>

The decision of the Court of Appeal was upheld by the Swedish Supreme Court. The Supreme Court found as follows:

In accordance with the contents of the Appeal Court's verdict, pursuant to the valid legislation it is a criminal act to deliberately take a person's life, even if this is done at the request of the latter. In principle, however, an action that can not be designated otherwise than as complicity in suicide is not punishable. The drawing of the boundary between perpetration and complicity is therefore critical for whether Hedeby's actions are to be considered criminal. This must be evaluated in accordance with general principles concerning liability for complicity within penal law...

On Handberg's request, Hedeby had promised to take measures with the intent that Handberg would die. These measures, performed with the intent mentioned, were included in an action plan drawn up by her in advance and carried out as a practically uninterrupted sequence. With regard to liability, the measures must therefore be regarded as one single act. By swallowing the barbituric acid tablets, Handberg participated actively in a moment included in the act. The course of the act - at the later stages, in which Handberg did not participate at all - was characterized, however, by such independent action by Hedeby that her participation has to be judged as perpetration. Thus, Hedeby has to be considered to

249 Case No. 139 (1979), *Nytt Juridisk Arkiv* (I: 1979), pp. 802-817.

250 *Ibid.*

be the perpetrator causing Handberg's death, whether this happened because of the administration of barbituric acid or insulin or a combination of these substances.<sup>251</sup>

## Proposed Amendment Initiatives

To date, no initiatives have been undertaken to amend the current legal situation with respect to euthanasia and assisted suicide in Sweden.<sup>252</sup>

## SWITZERLAND

### Assisted Suicide

Pursuant to section 115 of the *Swiss Penal Code*, inducing or assisting someone to commit suicide is punishable with up to five years' penal servitude or with three years' imprisonment, if the perpetrator acted with a selfish motive and the suicide was attempted or completed. A selfish motive has been held to include financial gain and the desire to be freed from caring for a person. In the absence of a selfish motive, assisting in the suicide of another is not criminal.<sup>253</sup> Section 115 provides:

*115. A person who, for selfish motives, persuades or assists another person to commit suicide will be punished, in case of completed or attempted suicide, with penal servitude up to five years or with imprisonment.*

### Euthanasia

Section 114 of the *Swiss Penal Code* creates a separate crime for "homicide upon request" that carries a lighter sentence than murder. The section provides that anyone who kills with a compassionate motive and upon the earnest and urgent request of the victim is punishable by up to three years' imprisonment. Section 114 of the *Code* stipulates as follows:

*114. A person who ends another person's life for estimable motives, namely for pity, at the serious and urgent request of that person will be punished with imprisonment.*

Acts of euthanasia that do not involve an explicit request on the part of the person who is killed are treated as murder or manslaughter, depending upon the circumstances of the case.<sup>254</sup>

Thus, under the *Swiss Penal Code*, the actor's motive is the primary consideration in determining the actor's culpability. One author writes:<sup>255</sup>

Under the *Swiss Penal Code*, the actor's motive is the essential factor in determining the actor's culpability. The motive which caused the actor to commit the crime is relevant to determining the actor's dangerousness and in predicting whether or not he will repeat the

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251 *Ibid.*

252 *Euthanasia in Foreign Countries*, 1994/5.

253 *Ibid.*

254 *Ibid.*

255 "Euthanasia: Is It Murder or Mercy Killing? A comparison of the Criminal Cases in the United States, The Netherlands and Switzerland," (1990) 12 *Loy. L.A. Int'l & Comp. L. J.* p. 839. Also see Russel Ogden, "The Right to Die: A Policy Proposal for Euthanasia and Aid in Dying" (1994) XX:1 *Canadian Public Policy* 1 p. 10-11.

crime. The theory is that one who kills to gain a reward or a financial benefit will do so again, while one who kills out of mercy or compassion is unlikely to repeat the act.

### **Case law**

To date, there has been no leading case dealing with assisted suicide or euthanasia in Switzerland.

### **Proposed Amendment Initiatives**

At present, no reform initiatives have been undertaken in Switzerland with respect to the laws regarding assisted suicide and/or euthanasia.<sup>256</sup>

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256 *Euthanasia in Foreign Countries*, 1994/5.













